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Modern Clinical Psychology

BY

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To

ROSEMARY

"An accurate history of the thoughts and feelings of any man, for one hour, is more valuable for some minds than a system of geography; and you, you tell me, are one of those who would rather travel into the mind of a ploughman than into the interior of Africa. I confess myself of your way of thinking."—Letter of Charles Brockden Brown.[1]

[1] Quoted with permission of E. P. Dutton & Company, Inc., New York, as publisher in the United States, from *The World of Washington Irving*, by Van Wyck Brooks.

Preface

The true understanding of personality is the achievement of no one and the responsibility of everyone. Civilized living requires that we show some understanding toward our fellow man; intelligent living demands it. The ability to understand others, though largely an intuitive gift, is susceptible to improvement, and to make it increasingly effective nothing is more potent than the effort to put oneself "in the other fellow's shoes." Some of our most insightful literature is the intelligible transcription of this experience so that for the reader it is virtually an experience of his own personality. We call our greatest writers artists partly because their intuitive expressions are universal in scope.

This book is written expressly for those who, for whatever reason, seek to supplement the intuitive knowledge of personality that they already have. That the designation of the professional student of personality is "psychologist" or some other term prefixed with "psych-" is entirely incidental. No one is more a psychologist, in one sense of the word, than the effective businessman, husband or wife, poker player, voter, teacher, advertiser, physician, general, swindler, writer, painter, pastor, judge, salesman, attorney, fisherman, or showman. The deliberate attempt to improve one's intuitive capacity falls under the heading of psychology, and so this book is a book in psychology. But its orientation is in the direction of understanding personality. If this falls centrally within the area usually considered as reserved to psychology, well and good.

This book represents an attempt to integrate the author's personal experience in what he conceives to be the specialty of clinical psychology. It will be apparent at the outset that he has leaned heavily on what is usually called the psychodynamic approach, and that his debt is very great to Freud and Jung and their followers (although many of the latter might find his major theses strange doctrine indeed!). The work of Murray and Rorschach and Klopfer is basic to the present undertaking. Their dynamic approach to clinical problems represents, in the author's opinion, the extractions from psychoanalytic theory which have the most evaluative sig-

nificance for the psychologist. Of a host of others whose impression on the author has been important, at least a few should be mentioned: Draper, Dunbar, Goldstein, Kardiner, Noyes, Piotrowski, Rogers, Sanford, and Wells. The author's close association with staff members at the Fels Institute, under Dr. L. W. Sontag, and with colleagues in psychology and psychiatry in the Navy during years when a basic point of view was being shaped and developed was an immeasurably valuable experience. And the author should certainly acknowledge his debt to two of his teachers specifically: Dr. H. W. Rogers and Dr. Orvis C. Irwin. Many colleagues helped immensely by reading portions of this book in manuscript and offering valuable criticism. The list is too long for individual acknowledgment, but particular mention should be made of the assistance of Dr. G. T. Lodge, Dr. R. N. Sanford, and Dr. J. T. Thickstun, who read most or all of the manuscript.

The attempt has been made to write this book at about the level of the college junior, who has had at least a year of general psychology. Usually the student who takes clinical psychology is already specializing; he is likely to be planning a career in psychological work. Despite this fact, it has been assumed that such a course would be of value also to the prospective physician, to the personnel consultant, the guidance counselor, or the psychiatrist, and the book has been written with these students much in mind.

T. W. RICHARDS.

YELLOW SPRINGS, OHIO,
June, 1946.

Contents

PAGE

PREFACE vii

CHAPTER

I. INTRODUCTION TO CLINICAL PSYCHOLOGY AS A SPECIALTY 3

Understanding the Individual 3
Relationship of Clinical Psychology to Other Fields 6
Training of the Clinical Psychologist 10

II. ORIENTATION TO CLINICAL PSYCHOLOGY. 13

Basic Point of View of the Clinician 15
Salient Aspects of the Personality That Must Be Understood . 15

III. METHODS OF PSYCHOLOGICAL APPRAISAL 20

Types of Information about the Patient. 20
Sources of Historical Information 20
Importance of Records 21
Nature of the Case History 21
Areas to Be Covered in Obtaining the Case History 22
Use of Charts for Chronology of Historical Events 27

IV. APPROACH TO THE PATIENT 30

Attitude of the Patient. 30
Attitude of the Clinician toward the Patient 32
Procedure in Initial Interviews 33
The Directed versus the Undirected Interview 34
Clinician's Procedure One of Successive Hypotheses and Testing of These 35

V. PHYSICAL EXAMINATION. 36

Necessity of Physical Examination in All Cases 36
General Physical Examination 36
Special Physical Examinations 37
Neurological Examination. 38
Endocrinological Examination 39
Examination of the Eyes and Ears 41
Pediatric Consultation 41
Importance of Treatment of Physical Defects or Disease. . . 42

CHAPTER PAGE

VI. APPRAISAL OF CAPACITY: I. METHODS OF STUDY . . . 43

Concepts of Capacity and General Intelligence 43
Evaluating Capacity from the Case History 45
Evaluating Capacity from Clinical Observation 46
Evaluating Capacity from Interview and Conversation . . . 47
Evaluating Capacity by Means of Tests. 48
General Procedure in Test Administration 49
Selection of the Test to Be Used 50
Tests of Capacity in Common Clinical Use. 51

VII. APPRAISAL OF CAPACITY: II. INADEQUACIES OF CAPACITY 59

Aspects of Normal Mental Growth 59
Mechanisms by Which Capacity Is Affected 61
Limitation in the Development of Capacity 62
Reductions of Capacity 67

VIII. APPRAISAL OF MOTIVATION: I. METHODS OF STUDY . . 76

General Considerations of Motivation 76
Clinical Techniques for the Study of Motivation. 83
Motivation as Reflected in Interests and Attitudes 85
Methods That Attempt to Quantify the Indirect Reflection of Basic Motivations. 86
Methods that Utilize the Projection of the Personality in Fantasy 89
The Patient's Autobiography as Dynamic Retrospection. . . 90
The Rorschach as a Measure of Basic Motivational Factors . 91

IX. APPRAISAL OF MOTIVATION: II. INADEQUACIES OF MOTIVATION 93

Uncontrolled Motivation; Infantilism 93
Maladjustments Associated Primarily with Inadequate Development of Sexual Motivation: Homosexuality. 103
Inadequacies of Heterosexual Behavior 120

X. APPRAISAL OF CONTROL: I. GENERAL CONSIDERATIONS AND CLINICAL METHODS OF STUDY 130

Overcontrol or Constriction 131
Fear and Anxiety. 131
Introversion. 135
Clinical Methods for the Study of Control 137
The Patient's Attitude toward His Present Situation 140
Nature and Onset of Illness 141
Test Procedures in the Evaluation of Control. 141

CHAPTER PAGE

XI. APPRAISAL OF CONTROL: II. ANXIETY AND ITS SOLUTIONS 151
Anxiety State 151
Unsuccessful Solutions to Anxiety 153
Unsuccessful Solutions That Are Socially Oriented 154
Hysteria 155
Unsuccessful Solutions to Anxiety That Are Personally Elaborated 160
Schizophrenia 162
Performances of Schizophrenics 167

XII. APPRAISAL OF CONTROL: III. THE SERIES OF INADEQUATE SOLUTIONS FROM THE SOCIALLY ORIENTED TO THE PERSONALLY ELABORATED 180
Neurasthenia 184
Psychasthenia or the Obsessive-compulsive Solutions 190
Epileptic Behavior 195
Paranoia 205
Depression 209
Manic Activity 215

XIII. PRECIPITATION AND PREDISPOSITION 226
The Situation 226
Situations in Normal Development Found Frequently to Be Particularly Frustrating 226
Fetal Period and Birth 227
Childhood and Adolescence 228
Adult Life 230
Illness 231
Brain Disease 234
Sudden Loss of Consciousness 235
Predisposition 236

XIV. READJUSTMENT 248
Reexperiencing Anxiety 248
Insight 251
Emotional Release 256
Release Outlets 257
Verbalization 267
The Clinician as a Projective Device 268
Role of the Clinician in Readjustment 270
The Concept of Therapy 271
Summary of the Clinician's Role 302

APPENDIX 305

BIBLIOGRAPHY 309

LIST OF VISUAL AIDS 317

INDEX 323

MODERN CLINICAL PSYCHOLOGY

CHAPTER I

INTRODUCTION TO CLINICAL PSYCHOLOGY AS A SPECIALTY

Understanding the Individual

Psychology is the study of behavior. Clinical psychology is the study of the behavior of a particular individual. Whereas the general psychologist is interested in the general behavioral characteristics of man and animals, such as learning or emotion or color vision, the clinical psychologist is primarily concerned with the total behavioral picture presented by the individual before him—his client or patient. His task is the evaluation of the personality and of the factors which are most important to the harmonious integration of that personality.

In approaching his subject matter—the individual—the clinical psychologist is likely to differ from his colleague, the general psychologist, in several ways. The problem of the clinician is, in most cases, a practical one: Where should Johnny go to school? How can Mary be induced to stop sucking her thumb? What lies behind Mrs. Smith's so-called "nervous spells"? Confronted with such questions, the clinician uses all the scientific knowledge at his disposal. But he draws heavily also on his experience with large numbers of cases he has seen and on his experience with things that have worked or have failed in similar cases. Provided with a sound training in the basic sciences pertinent to psychology, the clinician relies to a very great degree on his insight into personality, and he will use many and varied procedures to aid him in gaining this insight.

In practice, the clinical psychologist is less like the general psychologist than he is like the clergyman or the personnel manager or the physician. The concern of each of these is the proper evaluation of an individual at a given time and in a given set of circumstances. It is true that each of these counselors will approach the individual in his characteristic way. The personnel manager may make his evaluation in terms of the probability of

success on a particular job he has in mind; the physician may be concerned principally with the possibility of disease. Essentially, however, the primary task is the *understanding of the individual.* Without this understanding, counsel and guidance and treatment are very likely to be in error, and great harm may result.

Although the evaluation of the other fellow's personality is as old as man, the refinements of procedure that characterize present-day clinical study have developed over a long and labored path. Clinical psychology, which represents a high technical refinement of personality evaluation, is relatively a new profession—so new, in fact, that it is often misunderstood by practitioners in other professional fields and by the general public. In order to avoid such misunderstanding, it is important to consider what its sources have been.

Until recent years, psychologists themselves have been slow to develop standards of training and experience to act as criteria of professional standing and excellence. Because of this the term "psychologist" has been used by a wide variety of persons, from palm readers to efficiency engineers, and from sexologists to college professors of long academic standing. The American Psychological Association, particularly its section of applied psychology, and many smaller organizations of trained and responsible psychologists have worked very hard since the beginning of the century to give the term "psychologist" a real and standard meaning.

Today, it is generally considered that college training plus a master's degree in psychology is a minimum requirement for the psychologist, and to be qualified for full professional service it is necessary that the psychologist be accepted for membership in the society mentioned above and have a doctor's degree in psychology. Even these standards, which apply to general psychologists, are insufficient for the specialty of clinical psychologist. Internship and clinical experience beyond academic training are now required for qualification as clinical psychologist.

These efforts by psychologists to establish standards for their profession were the result of certain popular but mistaken notions about psychologists that continue to exist, even though they are erroneous. Because these mistaken notions still exist, and any psychologist may be personally misinterpreted as a result, it is well to consider some of them.

The most widely held misconception is that the psychologist is a glorified fortuneteller who, by means of palmistry or a glass ball or

the knowledge of a few of the patient's dreams, can see into the depths of his soul or predict his future. These are the "psychologists" who advertise in the daily paper. Many of these practitioners—or better, quacks—make a considerable fortune, usually at the expense of the uninformed.

A second misconception is that the psychologist is an academic master of sterile facts about behavior and a person with little practical common sense. This opinion is likely to be held by persons in practical affairs, who have little real acquaintance with higher learning and are suspicious of professors of any kind.

A third, and particularly dangerous, misconception is that the psychologist is a physician. Although some psychologists are also licensed physicians, the very great majority of psychologists are not; hence they are in no way qualified to diagnose or treat organic disease. The reason for this rather common misconception is not clear, but it is probable that the similarity of the terms "psychiatrist" and "psychologist" is partly responsible. Again, in much institutional work the service of both psychiatrists and psychologists is jointly required, and in the mind of the lay public the similarity of interests may suggest, erroneously, a similarity of function and responsibility. The responsible clinical psychologist has no hesitation in denying that he is a medical practitioner.

A misconception regarding the psychologist that appears very frequently in his dealings with other professions is that his interest and activities are limited to the giving of psychological tests. This is an insidious misinterpretation, but it has some logical basis because of the fact that psychologists very frequently use tests. Also, because the most widely known of these tests are tests of intelligence, it is often considered by responsible though poorly informed persons that the psychologist cares only about the I.Q., or intelligence quotient, of the patient. No adequately trained psychologist would feel that it was either important or possible to determine an I.Q. all alone; he knows that whatever an I.Q. is, it is simply one way of looking at the patient's behavior and means nothing unless it is evaluated in the light of other aspects of the patient's *total* behavior.

The administration of tests is an important part of the clinical psychologist's work, and no person who becomes a qualified clinical psychologist fails to become expert in the use of tests, known professionally as *psychometrics*. But the psychometrician is not by any means necessarily a psychologist. He becomes qualified as a

psychologist only when he is trained also in the interpretation of test results, clinical or behavioral findings, and facts in the patient's history and can integrate all this into an accurate appraisal of the patient's total adjustment.

Relationship of Clinical Psychology to Other Fields

From what has been said it should be apparent that clinical psychology, touching as it does all aspects of human adjustment, is very broad in scope. Since no one individual could master all the technical knowledge and skill required for a complete understanding of all aspects of adjustment, it is very necessary for the clinical psychologist to understand how his specialty is related to other fields and how best he can utilize other specialties in doing his own job.

Relationship to Medicine. Medicine, which is the study and treatment of disease, stands in very close relationship to clinical psychology. One reason for this is that physical symptoms are often prominent in human maladjustment, even though an organic basis for these symptoms cannot always be found. Complaints such as headache or physical weakness or even partial blindness are often, for the patient, the most significant aspect of his trouble, while, in reality, these physical symptoms are simply evidences of the patient's poor adjustment to life.

A second reason why medicine is closely related to clinical psychology is that the person who is physically ill always shows an alteration in personality. Many times the personality change is the only, or the earliest, symptom of a physical illness, and it becomes clear only later that organic pathology is basic to the symptoms. This is true in certain types of advanced syphilis as well as in milder disorders such as an overactive thyroid. A relatively frequent disease in childhood—encephalitis—often reveals itself only in the problematic behavior of the patient. It cannot be urged too strongly that in any behavioral maladjustment the possibility of physical disease must always be considered. Further, almost any physical complaint *may* have a basis in physical disease or pathology—even a broken bone.

There is a close overlap between medicine and clinical psychology in the study and treatment of severe behavioral maladjustments. In his training, the clinical psychologist traditionally regards this area of severe behavioral maladjustment as *abnormal psychology;* using the term "abnormal" in a sense very similar to that implied

in the term "disease." Medicine is concerned with disease, and it is only natural that those behavioral maladjustments which are so disturbing as to be interpreted as disease are of interest to physicians. The area of medicine which deals with the study and treatment of mental disease is called *psychiatry*.

In working with cases of severe behavioral maladjustment, then, the clinical psychologist and the psychiatrist have a similar function. These two specialists differ in two ways, however. Since the psychiatrist is always a physician, his interest is in mental disease and his background is one of training in the general study of disease, *i.e.*, medicine. The clinical psychologist is interested in the behavioral adjustment, not only of abnormal (or diseased) individuals, but of all kinds of people. It is essential that the clinical psychologist have the training of the psychiatrist in abnormal psychology and psychiatry if he is to work to any great extent with severe maladjustments. However, many clinical psychologists deal primarily only with minor maladjustments of normal individuals, and feel free to refer cases of severe maladjustment either to the psychiatrist or to the psychologist qualified by training for dealing with such patients.

Clinical psychologists differ from medical men, including psychiatrists, in a second and extremely important respect, one having to do with restrictions placed by law on the psychologist. Certain techniques, principally those involving drugs, are permitted only to the licensed medical practitioner. Psychologists and many psychiatrists are not primarily interested in these techniques, since they feel that for most cases psychological methods are not only adequate but more effective. However, it is important for the student to know that the law is very specific in reference to activities of non-medical practitioners.

The specialty of *psychoanalysis* should be mentioned in passing. The term "psychoanalysis" means, of course, analysis of the mind, and in a general sense any careful study of the psychology of the patient may be considered psychoanalysis. However, the term as used professionally has quite a restricted and specific meaning, and refers to a particular technique of study and treatment used by specially trained practitioners, who themselves are called "psychoanalysts." We shall discuss this technique in later chapters. The psychoanalyst is usually a physician. He has himself undergone psychoanalysis. His professional activity, like that of the usual

psychiatrist, is largely restricted to the diseased patient. Even though the psychoanalyst is a highly specialized practitioner, the influence of the psychoanalytic approach has had a generalized and considerable effect on psychiatry and clinical psychology. Many clinicians use concepts of psychoanalysis in their interpretation of psychological problems, with both normal and abnormal individuals. In so doing they are not, however, psychoanalysts.

Many of the professional opportunities for clinical psychologists are directly associated with medical activities such as hospitals, research organizations, and general clinics. In such situations, the psychologist may have routine clinical duties such as responsibility for all psychometric work and its interpretation, or he may act as a specialized consultant only on cases requiring unusual study. He may function as an assistant to medical clinicians, or he may have autonomous standing as clinician in the psychological area. Professional relationships in the medical field, so far as psychologists are concerned, have no fixed pattern, and the psychologist has been able in many instances to develop his own specialty in his own way.

Relationship of Clinical Psychology to Educational and Vocational Guidance. An important milieu for clinical psychological counseling is in those areas concerned with the optimal placement of the individual in his schooling or vocational activity. Indeed, the fields of school psychology and of vocational guidance have acquired the status of full-time professional activities.

Today the school organization of most large cities provides for a special bureau devoted to the education of handicapped, abnormal, or backward children. This bureau is usually under direction of a clinical psychologist and employs psychological specialists whose main interest is in the clinical evaluation and proper placement of school children whose adjustment is problematical. These specialists are trained in standard psychometric procedures and in clinical interpretation of findings. Usually they have had graduate training in psychology and have made a special study of childhood adjustment and maladjustments.

In the area of vocational guidance, psychologists are concerned quite naturally with later childhood and adolescence. Trained in general clinical procedure, their activities center about the special aptitudes and interests of the individual client with respect to the probability of success in specific vocational areas. The clinical psychologist who chooses vocational guidance as his specialty must

make a careful study of vocational requirements and opportunities. He finds it necessary in many instances to make at least preliminary analyses of jobs and occupations open to his prospective clients, and must maintain a working familiarity with generalized industry in his community.

Personnel and Industrial Psychology. A specialized adaptation of clinical psychology is made in industry, where emphasis is placed secondarily on the optimal adjustment of the client and primarily on the selection of the best worker for the job. This differing emphasis does not alter the professional requirements of the psychologist in any great measure, however; the task of placing the client in the optimal vocational setting requires, in general, the same sort of analysis of individual aptitudes and interests as the selection of the optimal worker for the job. Clinical psychologists in industry—often called "industrial psychologists"—are among the best paid specialists. They have been responsible for the development of many of the best substantiated techniques, for the reason that the effectiveness of their procedures is measured against practical standards of efficiency, *i.e.*, how much money can be saved by adopting this particular test of worker adaptability?

Clinical Psychology in Delinquency. There are wide opportunities for clinical psychologists in association with courts, prisons, and institutions for the care of delinquents. Many cities sponsor clinics for consultation in such cases, and many institutions of detention employ full-time psychologists as staff personnel.

Offenses against society require psychological study not simply as forms of undesirable behavior, but primarily as unfortunate expressions of the personality, behavior which under different circumstances might be conditioned toward adjustment rather than maladjustment. The dynamics of crime are highly complex and to be evaluated only by means of study of criminals as individuals. The population of the penal institution is composed of the whole range of personalities in our society—persons who are normal in most respects and persons whose maladjustment is so severe that the incident of criminality is but a minor reflection of it. In recent years an increasing interest in the *individual* offender and a decrease in the tendency to dump criminals in a general category of psychopaths have enhanced our understanding of delinquency.

In one respect at least psychological study of offenders differs from most other clinical situations, and that is that the individual

is usually an involuntary client. This means that the clinician must exercise to a high degree the procedures that are most likely to instill confidence and cooperation.

Training of the Clinical Psychologist

Clinical psychology has been defined very broadly in a preceding section as the psychological study of the individual, and it was shown that it embraces an understanding of general psychology and many related fields. It is obvious that in his training the clinical psychologist must maintain as his central theme of study the human individual and the ways in which the individual may differ from his fellows.

Colleges and universities have today no standard established curriculum of study for the field of clinical psychology, although it is possible in many schools for the individual to plan a course of study that meets many of the standards of adequate training. Since work beyond the bachelor's degree is an almost universal prerequisite for professional psychological practice, it is important to integrate, if possible, the undergraduate and graduate courses. To do this successfully seems to require at least a preliminary analysis of what the goals of such a program are and how the usual courses in most schools may be integrated into a meaningful and economic whole. Emphasis must be placed upon the skills that are required of the clinician in actual practice.

In any college or university the course in general psychology, usually a sophomore-year course, is prerequisite to further study of psychology. For the clinical psychologist, this course is important as an introduction to the behavior and nature of man, but it is indeed only introductory. The important areas of study beyond the course in general psychology are presented in tabular form on page 11. They are arbitrarily divided in two ways, as primary and advanced, and as background, technical, and clinical.

The primary areas of study are considered essential for the student who wishes to enter professional psychological work as a psychometrist. These are basic to the advanced areas of study, which are necessary for the training of the clinical psychologist.

The background studies are areas that supplement general psychology in acquainting the student with the nature of man as a whole—physically and psychologically—and with his heredity and the environment, which so greatly determine his adjustment.

AREAS OF STUDY BEYOND GENERAL PSYCHOLOGY

	Elementary	Advanced
Background studies	General biology Chemistry Sociology Developmental psychology Educational psychology Abnormal psychology Principles of calculus Biography, autobiography, and the novel	Physiology Physical handicaps and disease Genetics and heredity Neurology Anthropology Human environment Principles of behavior Industrial and vocational psychology Psychiatry
Technical studies	Laboratory procedures in psychology Psychological tests and measurements Development of measurements Statistics (measures of central tendency, deviation, construction of norms, correlation) Individual measures of personality Tests of capacity, interests, and aptitudes	
Clinical studies	Problems of mental capacity Educational guidance Parent-child relationships Vocational guidance Speech Reading disability Behavior	Problems of physical handicaps Severe maladjustments (psychiatric problems, mental deficiency, psychosis, criminalism) Neurological and endocrine syndromes Psychosomatic problems

The technical areas of study are those areas within which the clinician acquires the skills and techniques he uses in his study of the individual.

The clinical areas of study are those areas which are concerned with the study *by the student*, alone but under guidance, of actual cases, *i.e.*, individual problems requiring clinical analysis, interpretation, and treatment.

In most universities the student may arrange conveniently a program covering the background areas as well as the elementary

technical areas. In only a few universities, however, can the clinical areas easily be covered, and the student elsewhere will need to exert himself to arrange for case-study material. His teachers may do much in making arrangements not only for him to attend demonstrations at near-by hospitals or clinics, but also for him to work with actual cases in such institutions as well as in prisons and in homes. It is important that the advanced student make every attempt to cover a wide variety of problems (not concentrate on criminals alone, for example).

In planning a training progam with the degree of doctor of philosophy in mind, two additional considerations must be made because of the traditional requirements for this degree: languages and the thesis. Almost without exception, reading ability in two modern foreign languages is required, and, because in the non-English psychological literature French and German are most used, these are usually selected. Within recent years there has been a tremendous increase in the number of significant Russian publications, so that Russian might well be one of the elected foreign languages. For most students an elementary course in grammar plus an additional year of reading are sufficient, if supplemented by individual practice in reading in his field of psychology.

The thesis for the student of clinical psychology should be developed largely out of case-study material; if this is impossible, the thesis should attack some experiment or problem that is significant in clinical interpretation.

CHAPTER II

ORIENTATION TO CLINICAL PSYCHOLOGY

There is an obvious and close relationship between clinical psychology on the one hand and abnormal psychology and psychiatry on the other. Since much of the maladjustment encountered by the clinical psychologist falls far short of the extremes of abnormality or mental disease, a book such as this must avoid undue emphasis on the psychopathological at the expense of neglecting minor difficulties in individuals who are essentially normal and healthy. Certain concepts of abnormal psychology are of importance in the study of maladjustment, and for this reason certain important aspects of this area of thinking are stressed in this chapter. At the outset, it is urged that the student avoid certain biases that may creep into his thinking because of the traditional way in which abnormal psychology and psychiatry are taught.

In traditional psychopathology (a term used to include the fields of abnormal psychology and psychiatry) it is customary to think of the patient's maladjustment in terms of *types* of mental disease, or at least as tendencies in the direction of certain types of disease. To think in such terms is to utilize the approach of the physician, who feels that if he can identify the disease, the course of treatment will be indicated. Thus, if he can establish in his own mind the existence of pneumonia, the treatment specific for pneumonia will be the obvious therapeutic solution to the problem.

Fifty years ago psychopathologists made careful studies of extreme maladjustment in order to differentiate classic types of mental disease, with the result that there now exist a number of *syndromes*, or patterns of signs and symptoms shown by the patient, which indicate a given diagnosis. With the diagnosis established, the clinician felt that the course of treatment was clear and that the diagnostic term for the disease had real meaning as typifying the implications of the case. Such categorization of mental diseases has had a profound effect on thinking in psychopathology. One result is that most texts in psychopathology today are organized to present

respectively the syndromes of most importance. Thus, the conventional text has chapters entitled Mental Deficiency, Dementia Praecox, Manic-depressive Psychosis, Organic Psychosis, etc. The usual text of this sort goes into great detail in stressing the differences between syndromes and the importance of placing the patient in one category or another so that classical treatment may be more easily appreciated.

Most psychopathologists today realize that for several reasons this categorization of syndromes is useful in a limited sense only. First, very few actual personalities conform to the classical syndromes, and many personalities show the characteristics of more than one. Thus, psychoneurotic features often appear in mental deficiency, and many psychopathic personalities are intellectually dull.

A second and more serious objection to the categorization of psychopathological behavior is the increasing realization that mental disease, unlike pneumonia, develops not as the result of specific infection but out of a pattern in which the whole life of the individual, his environment, and even his very early childhood are of significance. Severe maladjustment is a highly personalized affair. In attempting to understand severe maladjustment, the clinician uses one part diagnosis to twenty parts study of the dynamic or developmental pattern of the patient's present condition. In other words, for proper evaluation of what should be done to help the individual, the clinician must understand how his patient arrived in his present predicament—*i.e.*, the *psychogenesis* of the maladjustment.

The clinician will find, however, a certain utility in becoming acquainted with the classic diagnostic categories. In his professional relations with colleagues, he will frequently encounter concepts and modes of thinking that emerge from this conventional categorization of behavior. In institutional and legal practice diagnoses are of statistical utility, as, for example, in promoting institutional legislation. Indeed, certain concepts that will be developed further in this chapter emerge from the semantics or meaningfulness of these traditional syndromes.

Because of these secondary reasons for the clinician to have some acquaintance with the conventional psychopathological diagnoses, there is presented in the appendix the nomenclature for psychiatric disorders recognized and recommended by the American Psychiatric Association in 1934. This list of categories may appear confusing

and meaningless to the student at this stage, but the relationship of each term to clinical interpretation of case material will be presented in the course of this book.

Basic Point of View of the Clinician

To the clinician, the distinction between normal and abnormal has little meaning. He thinks of the human being as in a constant state of adjustment and readjustment, of continual adaptation to his environment and to tendencies within himself. The task for the clinician is to understand the problems faced by the patient and the way the patient solves or attempts to solve these problems. The patient's solutions may be successful and as such be regarded as signs of good adjustment. But as the solutions to his problems are only partially successful or fail entirely, so his adjustment is considered inadequate and indicative of psychopathology.

All of us encounter situations in which it seems that any alternative would fail, and we find ourselves uncertain and worried. At such times it may seem easiest to dodge the issue entirely and go to a show instead—to forget the whole business. Decisions regarding one's future may often result not so much in activity toward the goal as in daydreaming about the fruits of success. Or one may beg off from an admittedly important but unattractive engagement by pleading headache. Together with assurance in meeting new situations, such minor evasions are frequent in the lives of the best adjusted people. But such evasions, minor though they be, are also psychologically the essence of maladjustment, for they are unsuccessful solutions of the problem at hand. Exaggerated, they become the basis of neurosis and severe maladjustment.

Salient Aspects of the Personality That Must Be Understood

For purposes of theoretical orientation to clinical study of the personality, this book proposes three aspects of the personality that must in all cases be approached, namely, *motivation*, *capacity*, and *control*. These concepts are discussed briefly from the theoretical point of view in this chapter; they will form the basis for later chapters in clinical method.

Motivation. On the surface the objectives of persons about us seem widely diverse. One man wants the security of a steady job, so that he may support his family unmolested and unworried. Another wants wealth, even at the sacrifice of friends. Another

seeks fame as a great artist or writer. But another may wish to travel alone, unhampered by social ties, uninterested in family life. In these diverse objectives, there is a common goal, however, which may be called the goal of ego satisfaction. Each man wishes to preserve his personal integrity, to find and maintain a place in the world. To one this may mean that he must be rich, to another that he must be unhampered by social traditions. To the child it often means an outburst of self-assertion. The well-adjusted individual appears reasonably satisfied with his lot. The minor dissatisfactions and discouragements he encounters seem to stimulate him to constructive activity in an effort to maintain his self-satisfaction.

Even the infant, whose awareness of self is uncertain and is observed with startling simplicity when he notices his hands for the first time—even the infant maintains in his life of sleep and feeding a personal integrity that is outraged by a sudden noise or by an interruption to his feeding. Such interruption is likely to result in a simple and effective response—a loud and certain cry—which, though perhaps his only possible means of reattaining peace, usually accomplishes the desired result. As he grows older and as self-awareness becomes more and more observable, it is accompanied by an increasing awareness of the environment. The infant begins to notice his surroundings, his crib, and, later, objects that he learns to manipulate.

As this awareness of the self and of the environment emerges, there emerges also an awareness of the source of comfort, of satisfaction to the ego. To the infant, food and warmth are the basic requirements to be supplied from his environment, and these the mother provides. In this complex total-picture, or *gestalt*, of physical needs and satisfaction, of warmth and food and mother, the mother assumes a meaning of valence for the infant that is of total significance in his emotional life. It is understandable, then, that the infant's need for security should become, in effect, a need for the mother.

As the child develops into adulthood, this need for security, early in life experienced as a need for the mother, takes on an individualized aspect, depending on the life history of the individual. But the basic need for love and acceptance and for ego satisfaction is present in some form in all of us. This need, and the manner in which the patient seeks to satisfy it, is central in the dynamics of

the personality. We shall see in later chapters that the frustration of this drive is expressed in many unusual ways.

Capacity. It is characteristic of the well-adjusted individual that he has the intellectual capacity to achieve his goals and to meet the demands placed upon him by his environment. Hence, it becomes important in any clinical study to understand the mental capacity of the patient, for in knowing this we can evaluate at least one possible source of frustration.

Capacity may be considered the total possible output of the individual, and, when we measure capacity under conditions of optimal motivation, we can learn in some measure whether the patient has "what it takes" to meet the demands of his particular environment. In some cases the individual is simply too dull to make the grade, whereas if he were placed in another situation he would adjust quite adequately.

It is in the detection of reduction of capacity or psychological deficit that we find rich clinical evidence to aid in understanding maladjustment. One's output may be reduced in many ways. Physical defects such as paralysis or loss of a limb may so reduce the individual's efficiency that his production is correspondingly reduced. An early reduction in capacity often occurs as the result of birth injury. Any damage to the nervous system, whether through head injury, old age, or disease, may reveal itself in a reduction of capacity or in a distortion of the picture of intellectual output.

One source of reduction of capacity lies in the area of emotional interference. Often one encounters an intelligent individual so tied up with worries and anxiety that he is unable to function at the level of his capacity.

It should be clear that the measurement of capacity to meet the demands of the environment and the detection of any reduction in capacity are extremely important in any clinical study, for they reveal significant avenues for further study of maladjustment.

Control. By control is meant the process by which the individual utilizes his capacity and curbs his impulsive motivation into useful channels of socially acceptable adjustment. In normal development the child gradually learns that to express impulsively his whims of the moment may result in disaster and that often he must temper his real feelings of open affection or hostility by using more acceptable and civilized adaptations, such as tact. Indeed,

the acquisition of control may be considered as the process of civilization—or better, of emotional maturity, an evolution whereby the infant becomes the adult.

Control is exhibited by the well-adjusted individual in the refinement of his behavior toward other people; he appears at least outwardly to temper his own selfish motivation with consideration for others. It is shown also in the degree to which the individual has developed resources within himself, resources for acceptable forms of expression to replace primitive outbursts of emotion, such as artistic or creative activity, let us say.

The development of control has its earliest beginnings in infancy and occurs as an outcome of frustrations or restrictions placed upon the child. Indeed, all control may be considered to eventuate from the fact that one's impulsive expression has to be adapted to the world as it is.

If he is fed often enough, the newborn infant is an uninhibited creature. There are no restrictions placed upon him. Soon enough, however, the process of civilization begins in the procedure known as toilet training, and the infant gradually becomes aware of the fact that he is rewarded for exercising control, *i.e.*, retention of urine and feces, until the proper time and place are arranged. In his emerging awareness of self and of environment, the importance of restraint in the mother-child relationship thus becomes paramount.

Associated with lapses in toilet control and later with other normal but unacceptable expressions of primitive behavior, such as signs of interest in sexual matters, the child learns that many expressions are taboo—*i.e.*, they will meet with punishment. Punishment to the child is loss of love. As control develops the child acquires a sense of guilt for certain acts and even for certain thoughts, which, though they may emerge from normal interest and motivation, are nevertheless socially unacceptable and bad.

It is seen, then, that the acquisition of control, or civilization, is accompanied often by threats of loss of love and of frustration in self-expression. For this reason the preservation of the fine balance of dynamic factors that the exercise of control entails is a delicate matter and permits of frequent distortion.

It is in the unusual forms of control that much maladjustment reveals itself, and a few of the ways in which these inadequate forms of control are expressed should be mentioned here.

1. Overcontrol or *repression*. Some people are so afraid to express themselves for fear of the consequences that they maintain a rigid

resistance and inviolacy, often so extreme as to reduce markedly the capacity for effective behavior. Many slightly overrepressed individuals use alcohol to reduce this control.

2. *Undercontrol* or overexpressiveness. Here we find that civilization has failed to advance far enough and that the individual, uninhibited and impulsive, aggressive and affectionate, is *too* responsive. He lacks the restraint characteristic of emotional maturity.

3. Tentative control or *anxiety.* Often the individual's impulse to expression, even though not recognized as such by himself, is strongly in conflict with the repression he has exercised, and he is left in a state of fear of the consequences, a condition of apprehension and uncertainty which may be called *anxiety.*

4. Distortions of control. By this term is meant forms of *inadequate control* which the individual has developed to resolve the conflict between primitive self-expression and social acceptance. They are attempts by the individual to render socially acceptable or tolerable a free indulgence in ego satisfaction. Frequently encountered forms of distorted control are

a. Psychosomatic outlets, in which the individual, unable to find a successful mode of adaptation, achieves acceptance and tolerance by means of physical symptoms. Often these physical symptoms are expressed in generalized weakness and lack of energy, when they are described as *neurasthenic.* In other cases, these symptoms approximate those of specific physical disability, such as paralysis or blindness, in which case they are called *hysteric.* The nature of psychosomatic symptoms—the kind and degree—is very often a function of the nature of the conflict. Many illnesses of psychosomatic genesis, such as gastric ulcer, culminate in definite physical tissue damage.

b. Withdrawal outlets, in which the individual, finding adaptation to the demands of the environment too difficult, indulges in daydreaming or fantasy where full play is given to expression of basic impulses of self-expression and ego satisfaction is realized. This creation of a private world represents a withdrawal from the real world and in extreme cases is called *schizophrenic.* Milder forms develop often in attempts by the individual to dispel the threat of the environment by taking refuge in routine and ritual, with rigid precision; this form of outlet often develops out of all proportion to the demands of the situation and may be called the *obsessive-compulsive.*

CHAPTER III

METHODS OF PSYCHOLOGICAL APPRAISAL

Types of Information about the Patient

In order to arrive at an understanding of his patient, the clinician at the outset needs much information about him, and from a number of sources. This information is in general of three types: *historical*, *quantitative*, and *impressionistic*. The first type, the historical, includes all facts in the patient's past life that are pertinent to an understanding of his personality. This historical material is the chief point of emphasis in the present chapter. Following chapters will deal with both the quantitative and the impressionistic types of material. They include the findings that result from the use of tests and measurements, and the interpretation of behavior and speech as observed in the course of the interview.

Sources of Historical Information

Although in most cases the patient himself is a fairly reliable source of information about his history, in some cases he may be so withdrawn or resistant that he will not readily give needed facts; in other cases the patient may simply lack insight or self-understanding, and hence be unable to give meaningful material. Young children are particularly unreliable sources of some information. In certain other cases the patient may deliberately misinform the clinician as a method of evasion. In all cases, however, it is important to elicit from the patient as much material as possible. This can be checked for accuracy against information from other sources, and it may be supplemented where needed.

Information may, in almost all cases, be obtained from the referral agency or person. Children in most cases are brought in by parents or teachers—both valuable sources of information. Courts referring delinquents may be expected to provide at least the facts concerning the current charge, and often they have records of past offenses. Any such information, no matter how fragmentary or apparently irrelevant, may be of importance.

Where there is reason to suppose that the obtainable historical

material is distorted or too fragmentary to be useful in case analysis, it is often possible through social agencies to obtain a social case history. The social case history is usually obtained by a trained social worker, who may visit the home or school or neighborhood in order to acquaint himself directly with the social milieu in which the patient lives.

It is a good general principle to ask in all cases for a written report from the referral agency, which states the reason for referral and gives briefly all pertinent data so far gathered.

Importance of Records

So far as possible, all data concerning the patient should be written in some way into the patient's record. In the early stages of case study, even material apparently irrelevant may be of importance in later interpretation. The clinician may wish to use standard forms or a loose catchall folder for the individual case. In any event, he should get the information on record. The clinician's memory is probably no better than that of anyone else. A second suggestion about records is this: record information as soon as possible before forgetting takes its toll or the interference of the next case confuses the picture. This does not mean that notes need always be taken directly in front of the patient, but it does mean that much valuable material will be preserved by writing notes within a few hours after the information is gathered and before other cases are studied.

Nature of the Case History

There is among clinical workers some disagreement as to the procedure to be adopted in obtaining history material. Some feel that a routine covering of certain areas is important in all cases. Others feel that the important aspects of the history in one case are of little significance in another and that stress should be placed on different aspects in different situations. For the student in training, it is strongly urged that a standard procedure be used. This is because at the outset of case study it is impossible to tell what facts will be of importance. In the case of a child who has temper tantrums, it may turn out that the attitude of parents in dealing with them, the possibility of some undiagnosed illness early in life, relations with siblings—all or any one of these things may stand out as salient. For this reason, the remainder of this chapter is devoted to the areas

to be covered by the case history. We shall here disregard the source of the information, taking up in a later chapter the approach to the patient for purposes of gathering history or for other purposes.

Areas to Be Covered in Obtaining the Case History

Identifying Data. This includes name, age, religion, race, referral agency, and date of birth. Be sure that details here, in spelling and dates, are accurate. Get full names.

Genetic History. Here is included information about parents and their sibs, grandparents and their sibs. Typical questions would be: Are patient's parents living? Of what and at what age did a parent die? How old was patient at that time? At what age and of what did grandparents die? In the genetic background are there indications of mental disease, nervous breakdown, fits (epilepsy?), alcoholism, or chronic illness of any sort? Get names and ages of parents and siblings, showing patient's relation.

Hereditary influences on the patient as factors in his maladjustment are never clear and in no case do they explain it. However, whether hereditary or not, characteristic forms of maladjustment such as dullness, emotional instability, tendencies to have fits, and even mental disease appear often in the family history and suggest possibilities of constitutional predisposition or unusual environment.

Personal History of Patient. 1. *Environmental Factors.* Get an accurate chronology of where and with whom patient lived during all of his life. Who had most to do with his early care? (Usually parents.) What were these persons like? How did they treat the patient? Was there conflict between parents? Separation? Divorce? Which parent did the patient prefer, if either? Get father's occupation and some impression of his financial status. Did mother work? Was the child rejected or loved intensely? Relations with siblings are important. Were there preferences by patient, by parents, by brothers and sisters? Was the child witness to chronic illness in the home? Numerous other questions of this same sort may be asked. The general task here is to arrive at an understanding of whether interpersonal relations early in life may not go far to explain patient's maladjustment today. We shall see, as we proceed, that early emotional experiences of the child do much to mold the future adjustment. Hence, forces which may have had exceptional or unusual emotional value in these years must be understood.

2. *Infant Habits.* Was patient's early development considered normal? At what age did he stop wetting the bed? Was bowel control established? Were there difficulties in this training? When did patient walk and talk? Did he suck his thumb, bite his nails, or indulge in any unusual habits? Temper tantrums?

3. *Physical Illness.* What are the facts concerning patient's birth? Was delivery rapid, prolonged? Was there evidence of birth injury? List all illnesses or periods when patient was considered ill for any reason, even if the diagnosis is vague. Find out about temperature and behavior in the case of all vague illness. Any fits, convulsions, dizziness, fainting spells, periods of "blackout"? Any persistent, chronic complaints such as eczema or skin rash, asthma, hay fever, or gastrointestinal upset? Has patient ever been struck unconscious by a blow on the head? At what age? How long unconscious? Was there any skull fracture? How do you know? Has the adolescent or adult patient had periods of illness which prevented him from doing his normal work? Has he sought medical advice for these? What were the psychological effects of illness on patient? Was he spoiled by attention? Did he show a marked change in personality as the result of any illness?

The importance of a careful history of physical illness cannot be overstressed. In many cases encountered by the clinician, physical factors are at the root of the present maladjustment. A primary consideration is the possibility of any damage to the nervous system by disease or injury. The onset of such damage is frequently not apparent at the time. In many cases, a careful analysis of the patient's present adjustment in the light of history of physical illness will suggest immediately that his problem is primarily one for medical or neurological attention, even though psychological factors are of considerable importance.

4. *School History.* Where did the patient go to school? What is his grade, or at what age and in what grade did he quit? Get accurately all failed grades or repeated grades. What were his strong and weak subjects? How did he get along with teachers? Was he truant? Why did he quit school?

This area is of particular importance to the psychologist because so many of his cases may be problems of school adjustment and for the added reason that progress in school tells us much about the child's mental capacity. It should always be kept in mind that most intelligence tests measure the ability to get along in school. (Hence,

the converse assumption can be made from the history that school progress is at least a rough indicator of intelligence, or what the patient's I.Q. might be.)

5. *Work History.* Did the patient help about the home? Was he paid or given an allowance at home? Did he work after school, during vacations? After quitting school, what jobs did he have? How much did he earn? How long did he hold a job, or jobs? Was he ever fired? Why did he quit? What work did he enjoy and do well? What would he like to do? The important conclusions to be drawn from the work (and school) history relate to motivation and control as well as to capacities and aptitudes.

6. *History of Delinquency.* Obtain a list of all arrests, the age at which they occurred, and the disposition of the case. What is patient's attitude toward these? Does he pass them off, excuse them, or is he ashamed and guilty? If he has "served time," what effect did this have on him? Many cases of delinquency will have had earlier contact with psychologists, social workers, and psychiatrists, so that earlier history material and case study will be available.

7. *Psychosexual Development.* This area should be covered in all cases and the account must go beyond the simple facts regarding overt sexual activities and the age at which they occurred. These should include intercourse with the opposite sex, with the same sex, masturbation, and any activities of an unusual nature. The role of sexual factors in emotional development is not always obvious. Overt and clearly sexual activities frequently are much less important than implicit sexual tendencies as expressed in interests and attitudes toward the opposite sex, and particularly in the fantasy of the individual. Close personal relationships early in the patient's life should be noted. Was the child breast- or bottle-fed? What were the parents' attitudes toward infant self-manipulation? To what sort of sex education was the patient exposed? Were there rude shocks at discovery of sexual activities? In adolescence and adulthood the nature of sexual expression is important. About when was the onset of pubescence (as menstruation in girls)? When did "dating" begin? When did the patient marry, and whom? Was it after long acquaintance? Get the ages and dates of marriages, separations, and as good a picture as possible of marital adjustment, including sexual activities and attitudes toward children. What is the attitude toward contraception?

In the case of women, the regularity of menstruation is important.

Is it painful? Are there subjective changes in the personality with the menstrual cycle?

Because of the intimate nature of the facts in this area, much of this material will be inaccessible or it will be obtained only with difficulty from whatever the source. (In most cases, a blunt introduction into the sexual area is likely to endanger the relationship between the clinician and his patient.) In many cases, the very inhibition of the patient when it comes to discussing sexual life will be a salient characteristic. In all cases, the gathering of facts regarding sexual development whether from the patient or others will require tact and understanding.

8. *Social History.* What sort of social adjustment has the patient made during his life? Is he a "lone wolf," or is he highly gregarious? Does he prefer to be with his own sex? Are his social outlets the usual thing for a person his age? What are his hobbies? What recreation does he choose? What does he read by preference? What are his ambitions in life? Is he religious, and, if so, in what way? Does he feel that others like him, avoid him, pick on him, or kid him too much? Does he avoid others because of embarrassment, or because he is too busy with his own activities?

9. *Behavioral History.* Include here all material regarding previous behavior trends of possible psychopathological importance. Has the patient ever had a nervous breakdown? At what age? What seemed to induce this? Has he ever consulted a doctor for nervousness, a psychologist or psychiatrist, ever been hospitalized for mental illness? Has he ever been considered queer or nervous? Does he stutter or stammer? Go "haywire" with no explanation? Is he considered moody—does he have ups and downs—feeling fine for a while, then in the dumps? Has he ever contemplated or attempted suicide? Does he have sudden bursts of temper? Has he ever felt like killing anyone? Ever heard voices talking to him when no one was near? Ever had a vision? Ever felt anyone was plotting to do away with him in any way? Who? Why?

The facts of unusual behavior of any sort and the situations in which it occurred or that seemed to be responsible are of extreme importance in any case history.

10. *Use of Drugs.* Does the patient use alcohol? How much and how frequently? What is its effect on him? Does he drink alone, before breakfast? Is he a periodic drinker? Smoke? How much? Any other drugs?

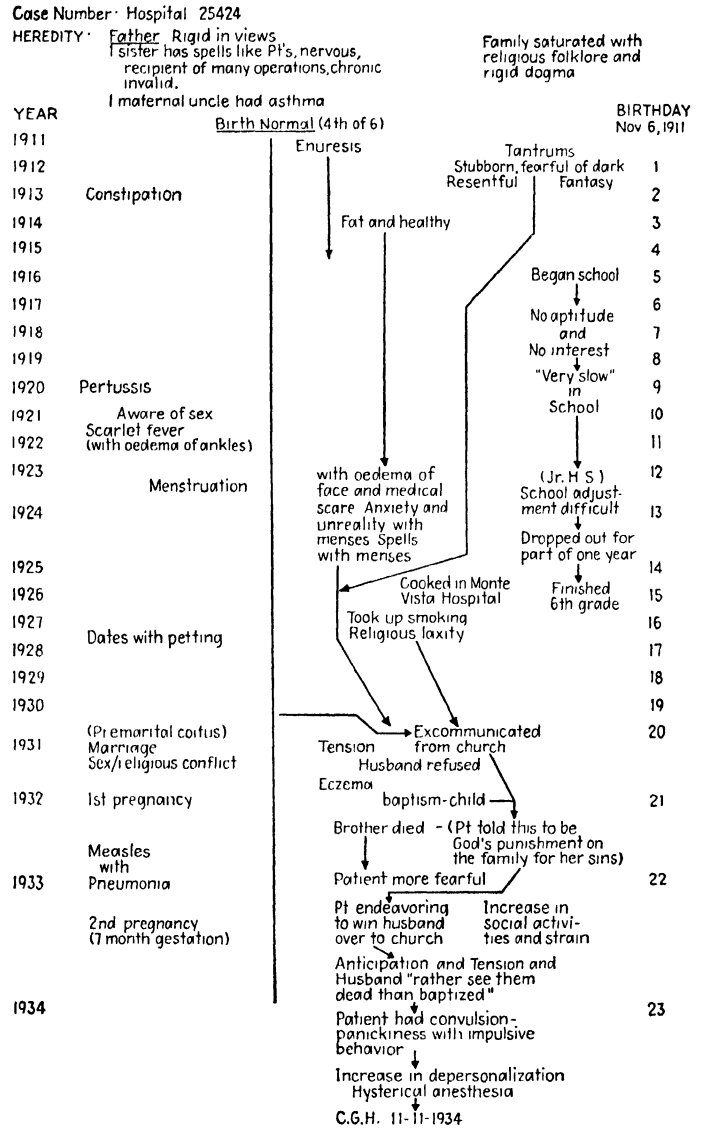

FIG. 1.—A life chart on which is tabulated the data of a clinical case. This chart is shown to illustrate the use of the longitudinal method in sorting out the dynamic factors that may contribute to the clinical problem. (*Adapted from Edward G. Billings, A Handbook of Elementary Psychobiology and Psychiatry, p. 229, The Macmillan Company, New York, 1939, with permission of the author and publisher*).

In some clinical situations, printed or mimeographed forms may be used for purposes of gathering certain of the information necessary for the case history. It is obvious that such a procedure makes certain demands on the informant, *i.e.*, literacy and some intelligence, and that the answers must eventually be checked for reliability. If the areas covered by the questionnaire are carefully limited and if the phraseology of the questions is simple and clear, much routine information can thus be obtained without involving the time of the clinician or staff personnel. Such forms are particularly suitable for use with adolescents and adults in vocational guidance, for example. When filled in by the patient, the questionnaire blank has the further advantage of being a first rough test of his capacity to understand, of his handwriting, and, when checked, of the accuracy of his self-appraisal.

One such questionnaire (devised by Dr. G. T. Lodge for work with naval recruits) is presented below and on the following pages.

Use of Charts for Chronology of Historical Events

In later chapters it will be seen that one of the most fruitful methods for analyzing and interpreting clinical facts is by longitudinal study of the patient's development. This means a careful study of the coincidence or of sequence of events—of symptoms and experiences—in the life of the patient. Because such an analysis is important in every case, and because the case history data will be heavily drawn upon in making such a study, it is very useful to make a longitudinal chart of this data. Adolph Meyer was among the first to suggest the clinical utility of the longitudinal chart. An adaptation of such a chart, provided by Billings (18), is presented in Fig. 1.

PERSONAL HISTORY SHEET

Co. No._____

Print your full name_____ Date today_____ Race_____

Birthplace_____ Birth date_____ Age_____

Place sworn in Navy_____ Date sworn in Navy_____

Birthplace of mother_____ Date arrived N.T.S._____

Birthplace of father_____ Father's occupation_____

Did you live with both of your own parents until you were 16 or older?_____

If your home was broken by death or separation of your parents during your childhood, explain briefly:_____

_____

Where did you last go to school?_____

Why did you quit school?_____

At what age did you quit?_____What was the last grade you finished?_____

What grades did you fail?_____

How many times have you been married?_____ Separated?. _____Divorced?_____

Widowed?_____

How many children have you ever had?_____

How many times have you fainted? _____Explain_____

_____

List all serious illnesses, accidents, operations, you have had, as follows:

Your age then	What was the trouble?	How long were you sick?

Have you ever had syphilis?_____ _____Gonorrhea (Clap)?_____

List all military experience (Army, Navy, Marines, Coast Guard, CCC, etc.)

_____

_____

List all employments you have ever had in the last five years (account for periods of unemployment):

Employer	Town and state	Just what did you do?	Wages	How long?	Year you quit

List *all* the arrests you have *ever had at any time*. Include all traffic violations except parking tickets:

Town and state	About how old were you?	With what offense were you charged?	Disposition: Jail? Probation? Dismissed?

Write here any other information about yourself that would be of value to the Navy in helping you find your proper place. (List interests and hobbies.)

Sign your name here.

CHAPTER IV

APPROACH TO THE PATIENT

Attitude of the Patient

Original impressions exchanged between the patient and the clinician are of utmost importance in the later development of the clinical case. The best procedure depends, of course, very greatly on the nature of the case, the reason for referral, and the special psychological service sought, etc. Depending on these factors, the attitude of the patient himself will vary. He may, if brought to the clinic against his choosing, be resentful of the whole situation, resistant, even antagonistic and openly hostile. Again, he may be indifferent, casual, and for the most part uncooperative—*i.e.*, passively resistant. It should be kept in mind that, for most people, consulting a psychologist or psychiatrist, even if it is deliberately sought, is an occasion for some loss in self-esteem. Most people become wary and suspicious if there is any likelihood that they will be considered queer. All of us have enough personal pride and sense of privacy to be put somewhat on the defensive in such a situation. Whereas some may be openly and obviously on guard, and hence resistant and antagonistic, others may be indifferent, and still others may be deliberately evasive and unreliable. Yet a different reaction is that of the individual who desires to cooperate but who is basically inhibited without himself clearly realizing it. Such an individual may be so shy or embarrassed that he cannot drop his defenses for a moment even though he realizes that this undesired withdrawal is detrimental to clinical study.

The clinician will occasionally encounter a patient who sincerely wishes help for a particular problem. Such an attitude offers the best prospect for the development of what is usually called *rapport*. Rapport implies a relationship between clinician and patient in which the latter is optimally cooperative, exerts his best effort to do well, and overcomes his natural inhibition sufficiently to reveal his true personality. The achievement of rapport is the objective

in all the clinician's initial contacts with the patient. Unless rapport is established, the clinician cannot be certain of the validity of any of his findings, whether they be test results or qualitative information.

It should be kept in mind in any first contact with a patient that from his viewpoint it is he, not the clinician, who is "on the spot," and that for this reason he will naturally be defensive. This is true even if he comes seeking help. His most probable attitude is that the clinician is an expert at understanding others, whether as a mind reader, a "crazy-doctor," or a professional but friendly adviser.

In dealing with children special problems of rapport will arise. Few children come to the clinic voluntarily, and for few of them does the prospect of clinical study appear to their liking. Often the child feels that he is seeing another doctor, and for some children the prospect of medical treatment is fearful. In such cases the clinician must devote himself first of all to the problem of rapport, and his best approach will be to present the entertaining aspects of the clinical study first. This may sometimes be done by proceeding at once with certain of the test materials, presenting them as games. Naturally the colored blocks or miniature objects that for the child are toys here offer the greatest possibilities.

Although as a general principle it is always desirable for the clinician to see his patient alone, in dealing with children it is sometimes expedient to have the parent in the room for a while at least. In such a case an early objective is to establish such rapport with the child as will permit the child and the parent to be separated very soon, so that the child may be interviewed or studied alone. Almost without exception it is bad practice to use tests or to interview the child systematically in the presence of a parent. There are several reasons for this. In many cases the child has unfortunately been prepared for his clinical study by the parent anxious for him to make an impression. In all cases, the child with the parent cannot feel free to reveal aspects of his personality that he knows the parent may consider undesirable.

While it is important for all parents to understand their children, and they are always curious about the results of examination, it is rare for a parent at the start to seek genuine understanding and insight. Usually the parent wishes to know the I.Q. of the child. Often the parent seeks only one thing, and that is confirmation of his or her long-formed opinion that the child is stupid or has a "bad streak" or is precocious. In such cases the clinician will realize the

necessity of therapy primarily for the parent and secondarily, if at all, for the child.

Many clinics actively recognize the special problem of establishing rapport with children by equipping, furnishing, and decorating the clinic with the tastes of children in mind. Often there is a playroom used as a waiting room, with toys, children's books and magazines, and pictures selected for their pleasing effect.

In his first interviews with older children, the clinician may wish to have a preliminary talk with the child—always at the child's level of thinking but without insulting the child's intelligence, with the objective of the study explained in a straightforward manner. Many older children are suspicious of adult deception (often understandably true of children referred by parents), but all children will respond to sincere friendship in adults and, above all, to honesty. A very successful procedure with some older children is to put the necessity of clinical study to the child as a straightforward, sporting proposition, one that he will find interesting in its own right. Placing responsibility on the child for his part of the proceedings is the best possible fore-runner to establishing in later therapeutic interviews an insight and the essential feeling of personal responsibility for making readjustment.

In cases of conflict between the child and authority—be this parents or the school or the police—it is extremely important for him to feel that the clinician, because he is an adult, does not thereby share the point of view of authority and hence lack the capacity to see the child's viewpoint. The clinician should never identify himself with either side of a conflict of this sort until he has carefully analyzed the situation from the viewpoint of the patient's readjustment.

Attitude of the Clinician toward the Patient

The wide range of attitudes the patient might take toward the clinician—and the latter's primary concern with the establishment of rapport—determine that he must, first of all, preserve an adaptability and resiliency in his preliminary contacts with the patient. His first objective must be to put himself in the place of the patient, get his point of view, and understand its validity. The clinician must take no moral stand whatsoever. He must neither condemn nor condone the position of the patient. To him the patient is an individual with a problem, a problem the solution of which has so

far been difficult or partial or inadequate or inappropriate. In any case the problem is not successfully solved in the present life situation of the patient.

Every moment the clinician spends with him has its effect on the patient and must be considered in this sense, desirably or not, as a part of the therapeutic relationship. In many cases a single interview will do most of the work in remedying a situation of maladjustment. In other cases the initial interview must be considered purely preliminary and as only the introduction to a long series of conferences.

It is essential that in all cases the clinician maintain an attitude of courtesy, consideration, and good taste. Sometimes this is difficult, as in situations of antagonism and even personal insult. In every case, however, whether pleasant or unpleasant for the clinician, the patient's behavior must be considered to be the expression of his personality—the material to be understood and interpreted in the light of this particular individual's life problem, his goals, and his frustrations in achieving these goals. The patient's complaints should never be taken lightly no matter how unreasonable or unfounded they may appear. To the patient his complaint is a very serious problem. There may, indeed, be a physical basis for it. For him to detect in the clinician's attitude anything of ridicule or patronage or superficial tolerance may cause resentment and destroy all possibility of rapport. This is not to say that the clinician must be morbidly serious in his attitude, but rather that a relationship of mutual personal respect and confidence is essential.

Procedure in Initial Interviews

We see, then, that the actual procedure in the first interview is a matter of individual adaptation to circumstances. From the practical point of view, there is often thrust upon the clinician without his choice a point of departure for immediate conduct of the interview. An example is that of the patient with a particular worry on his mind—possibly he has been sleeping poorly and seeks help. With such a direct question the clinician can follow up with questions about the complaint and lead gradually and pertinently into other areas of importance. In another instance the patient may be referred by a police court because of a specific offense, the circumstances of which are a logical point of departure since they are uppermost in the minds of all concerned.

In many cases the clinician will wish to use his first interview to obtain the case history, since this material affords him data for a preliminary analysis of the case as a whole and suggests a procedure for subsequent interviews. Most patients expect a review of their history early in the clinical procedure, and to some it is reassuring to have the clinician take a detailed interest in their personal past. In a sense such an interest is flattering and leaves a good basis of confidence for further interviewing.

A point of technical importance concerns the avoidance of bias on the part of the clinician. Where one uses tests and examinations of the type in which bias may influence the interpretation, it is sometimes desirable for the test results to be obtained prior to impressions from observation or interview. An example is the use of such an examination as the Rorschach ink blot test in a case of possible brain concussion. The Rorschach, at least in interpretation, is not a strictly objective test. The clinician aware of a history of concussion may be more likely to find confirmatory evidence in the Rorschach results than he would be without this knowledge of history. Awareness of this tendency toward bias ought, however, to be enough to correct for it, and this done, the use of test procedures purposely to obtain confirmatory evidence can be an extremely valuable procedure.

The Directed versus the Undirected Interview

The clinician finds that many patients, with very little suggestion or stimulus, will elaborate a beautifully organized and fairly complete case history within a short time. It is obvious that it would be not only inefficient but offensive to such a patient to interrupt and restrain him. In such cases, however, it is well to consider that the patient with such a logical account of his own adjustment may well be biased and is using his logic to avoid unpleasant or unacceptable interpretations. Since, as we shall see later, much therapeutic benefit arises from the patient's thinking his own way through his problems, it is well to allow him in most cases a chance at least to tell his story. For many reasons the patient's interpretation of his problem is always an important area of clinical evidence and should always be sought. This relatively free procedure of allowing the patient to interview himself, so to speak, sometimes leads nowhere, as in the case of the patient whose thoughts are disconnected or illogical or irrelevant. In such cases, the clinician can himself

gradually assume direction, having already gained a valuable insight into his patient.

With most patients, particularly until rapport is well established, the clinician will need to do much active probing. With tact and patience this inquiry can be carried inoffensively and in such a way that the patient steadily gains insight into important factors in his life. Many patients have actually had no previous experience at self-review or self-analysis or self-understanding. Many have never assumed the role of looking at themselves from the outside, as it were, and in the course of initial interviewing must actually be taught to see themselves as they appear to others.

Clinician's Procedure One of Successive Hypotheses and Testing of These

From the first impressions made by the patient to the final demonstrations as the result of careful subsequent study, the clinician engages in forming hypotheses which explain the patient's difficulty, testing these by further study and probing and experimenting, discarding inadequate hypotheses, re-forming his interpretation, and again testing for error. He may catch immediately in the unusual, inappropriate laugh of the patient a strong suggestion of a schizoid trend but find on further study that there is little else to support a picture of schizoid personality and that the observed laugh was not at all a typical behavior sample. The need to form and re-form hypotheses to explain the patient's maladjustment suggests the procedure to be followed as the interview proceeds and, indeed, the procedure most sensible in subsequent case study, measurement, and experiment. In the study of the patient, it is the clinician's ultimate satisfaction with his interpretation which determines the course of therapy or disposition of the case. In some instances, he may, after a brief single interview, form his opinion satisfactorily, while in others he may, to satisfy himself only partially, require hours of careful study.

CHAPTER V

PHYSICAL EXAMINATION

Necessity of Physical Examination in All Cases

No specialist in personality study feels adequate to rule out the possibility of physical disease in any case without benefit of a complete physical examination by a qualified medical practitioner. There are several reasons for this.

1. No matter what the psychological examination may reveal, it is always possible that the patient is suffering from physical disease. This disease may be basic to the maladjustment for which counsel of the clinician is sought, or it may be entirely secondary to the reason for referral. Where physical disease exists it must be recognized and treated. In some cases it may be important to institute medical and psychological treatment simultaneously.

2. Many of the clinician's patients will present minor or even major physical complaints, and many another will reveal in his history the importance of physical symptoms.

3. In the minds of most people, physical illness is in some way responsible for, or a part of, or basic to, psychological maladjustment. For this reason, it is extremely important for the attitude of the patient that he be assured of complete physical as well as psychological study.

4. Though the clinician may neither claim nor attempt to treat physical disease, he lays himself open to criticism and even litigation if it can be shown that he has neglected physical factors in his psychological appraisal.

General Physical Examination

Any qualified physician can do a general physical examination, the purpose of which is to examine all systems in order to detect disease. A careful examination requires approximately one hour.

Cases may be referred to the physician in several ways, but the method preferred by the medical profession is to allow the patient himself to choose a physician. Probably the optimal choice is the

family physician, since he is most likely to be aware of disease history and tendencies. If the patient is at a loss when it comes to choosing a physician, one may be recommended. In referring the patient to a physician for examination of any kind it is courteous and correct to write a note to the physician stating the reason for referral and requesting a report.

A report of the physical examination is important as a record for immediate and future reference and may reasonably be expected of the physician. From the clinician's viewpoint, the report is satisfactory if (*a*) it states clearly and unequivocally the existence of any physical defects or disease, and (*b*) if such exist, it suggests what treatment is indicated; if none exists, the report should state that there are no apparent physical defects or disease.

In most institutional situations, physical examination is made routinely without the necessity of a request by the clinician. In institutions such as hospitals, schools, and courts, the physical examination usually precedes the referral to the clinician. Probably it is only in private case work that requests for special physical examination will be necessary.

Usually reports of physical examinations preceding the psychological referral are accessibly filed somewhere. The clinician has every reason and right to use such reports, for they constitute an extremely important part of the case study.

Special Physical Examinations

One result of the general physical examination by the physician or of preliminary psychological examination will be the need for further examination by a medical specialist. If such special examination is indicated by the general physical examination, the examining physician will usually say so in his report, recommending the type of specialist. It may be obvious to the clinician at any stage in his study that special physical examination is required, and it is important for him to be familiar with those areas of specialty in medicine which are most pertinent.

Any area of medical specialty may be of importance in any case. Types of special examination most frequently required are examinations of the nervous system (neurological), of sense organs, particularly the eyes (opthalmological) and ears (otological), of the endocrine glands (endocrinological), and in the area of diseases of

childhood (pediatric). These will be discussed in further detail in this chapter. An orthopedic examination is often needed in cases of physical handicaps. An internist (or specialist in internal medicine) is often consulted in heart, lung, and gastrointestinal cases and when obscure generalized illness is suspected. A dermatologist is consulted for skin diseases and often in cases where syphilis is suspected. The urologist (diseases of the genito-urinary system in men) is a specialist in venereal disease. Cases of suspected diseases peculiar to women are referred to the gynecologist. These last two specialists are frequent sources of counsel in cases of sexual maladjustment.

Laboratory medical studies are frequently required, but almost always as their pertinence is indicated in physical rather than in psychological examination. Thus, in the general physical examination, tests of the blood and urine and sometimes the spinal fluid are required to rule out diseases such as anemia, diabetes, and syphilis. X-ray (or Roentgen ray) studies by a radiologist are important in many cases. In psychological cases particularly, X-ray studies of heart, lung, and gastrointestinal function, orthopedic defects, endocrine glands, and injuries to the brain are frequently necessary. The *electrocardiogram*, sometimes called the "EKG," is often required in studies of heart function. It is a graphic record of the electrical activity of the heart beat.

Neurological Examination

The neurologist is concerned with diseases or defects of the nervous system. In many psychological cases there is real possibility that the nervous system is not functioning properly. This may be due to disease or injury to the nervous system or their aftereffects. The neurologist makes a careful study of reflexes, of posture, of the eyes, of sensitivity of the skin, and of bodily symmetry. He may utilize X-ray studies of the nervous system, some of a specialized type called the *pneumoencephalogram*, which reveals shadows of certain of the inner brain structures. The neurologist frequently requires laboratory examination of the spinal fluid to diagnose diseases and injuries of the nervous system. This is sometimes called the *spinal tap*. An important special type of neurological diagnosis is the *electroencephalogram*, referred to as the "EEG." The electroencephalogram is a visible record made of electrical

activity in various areas of the brain. This activity is shown on the record by waves called "brain waves." Analysis of various patterns of these waves shows that they are related to activities of the individual, such as vision and movement, and that persons like epileptics who show other signs of unusual brain activity reveal unusual trends in the brain-wave picture. Brain-wave patterns of variously maladjusted individuals have been analyzed, with the result that the electroencephalogram is becoming an important aid in the evaluation of many psychological cases. In his study of the nervous system the neurologist does not confine himself to the brain and spinal cord and the nerves responsible for sensation and bodily movement. He is interested as well in the *autonomic* or *sympathetic nervous system*, which mediates the control of body metabolism and is greatly involved in the involuntary activities of the individual such as breathing, heart action, sweating, and endocrine function. This system is extremely important in its association with emotional response, for many emotional upsets are associated with disturbances in these involuntary functions of the body. Fear, for example, is characterized by changes in breathing, sweating, increased heart action, and abdominal sensations. Because of this close association, examination of the autonomic nervous system is an important corollary of psychological study.

Tests of activities governed by the autonomic nervous system are made on gland activity, secretion of saliva, circulatory activity, breathing, and many other functions. An important and frequently mentioned study is the measurement of the resistance of the skin to the passage of a minimal electric current. This *skin resistance* decreases with sweating, an autonomic activity. The measurement of skin resistance (sometimes referred to as the *psychogalvanic response*, as measured by the *psychogalvanometer*) can be made on various parts of the body but is most effectively made on the palms of the hands or the soles of the feet.

Endocrinological Examination

The precise nature of the relationship between the endocrine glands and personality and the extent to which these glands are involved in personality disorders is not fully realized, but it is certain that they play an important role. Glands of real behavioral significance are the pituitary, the adrenal (medullary or internal

portion), the thyroid, and the gonads (the ovary in the female and the testis in the male). The endocrinologist learns much about the patient by observing his appearance, bodily proportions, and the sluggishness or alertness of his behavior; by means of palpation (manual exploration) and X ray he learns also from the size of the glands themselves. Another aid in diagnosis is the response of the patient to the administration of glandular substances (hormones) or their end-products. One indirect sign of endocrine function is the measurement of *basal metabolism*, made by determining the oxygen consumption under known conditions of rest and reduced activity, where even the effect of diet is controlled. The *basal metabolic rate*, sometimes designated as "BMR," is an index that expresses the degree to which the measured basal metabolism of the patient varies from the normal metabolism of an individual of the same sex, height, and weight. This index is considered by many to be a reflection principally of thyroid function.

Examination paralleling in many respects the examination of the autonomic nervous system tells much about the function of the adrenal glands, for the reason that the effects of the substance formed in the medullary portion of this gland is similar to the influence mediated by the sympathetic portion of the autonomic nervous system. Hence, the endocrinologist will examine circulatory, respiratory, and gastrointestinal phenomena, as well as heat regulation and perspiration.

In addition to its association with growth in bodily size, the pituitary (sometimes called the "hypophysis") exerts many influences, the chief of which is an executive control over all endocrine functions. For this reason its malfunction may be evaluated in the general physical examination of the patient. The size of the pituitary can be determined at least roughly by means of X ray of the head and the shadow of the *sella turcica*, which is the bony cavity in which the gland rests. Urinalysis is sometimes revealing of pituitary function as well as function of the sex glands.

Considered to occur with the beginning function of the sex glands, the onset of puberty is governed by a product of the pituitary gland. Physical signs of puberty such as breast and genital development and bodily distribution of hair are accompanied by functional changes, such as the onset of menstruation in girls, the ejaculation of sperm by boys. In boys the voice becomes deeper. In both sexes the bodily contour begins to assume the adult appearance.

Where these changes are in any way abnormal the endocrinologist may find evidence of inadequate functioning of glandular balance, and since these changes are of tremendous importance in the adjustment of adolescents, the clinician may frequently have need for endocrinological consultation. Disturbance of endocrine balance throughout life is often characterized, as we shall see, by psychological maladjustment.

Examination of the Eyes and Ears

Many a child who is maladjusted in school and hence considered dull is found to possess adequate mental capacity but to be suffering from defective vision or hearing. In many such cases complete readjustment may be achieved by correcting vision with glasses or by aiding either hearing or vision through proper seating in the schoolroom.

The clinician himself may make rough tests of vision and hearing, but where defect is suspected he should always refer his patient to the specialist, the opthalmologist or the otologist. Again, many defects and diseases of the nervous system are accompanied by sensory changes particularly in the eye. By examining not only visual acuity, but the fields of vision and the appearance of the eye itself, the opthalmologist frequently makes findings of great diagnostic value in such cases as brain injury, concussion, or syphilis. In this sense, special eye examination may be considered to be a part of or supplementary to the complete neurological examination.

Pediatric Consultation

Because so many of his patients are children the clinician may have frequent occasion to refer cases for pediatric examination. The pediatrician is an internist who specializes in children's diseases; he is greatly interested in the maintenance of health in normal children and is expert in nutrition. Especially during infancy when the psychological development of the child is physiologically so manifest in nursing and eating behavior, in the excretory processes, and in gradually integrating patterns of movement and response is the nutrition of the child of particular importance. Knowledge of the physiology of childhood is basic to pediatrics, and the psychologist should be highly conversant with the major aspects of this same field.

Importance of Treatment of Physical Defects or Disease

In many of the cases referred to the psychologist, proper medical attention will completely ensure adequate readjustment. The child who needs glasses is a good example. Often of primary importance in any type of psychological treatment, medical treatment will be discussed in greater detail in the later chapters on therapy. As stated above, any recognized physical defect or disease should be treated by a physician.

CHAPTER VI

APPRAISAL OF CAPACITY—I. METHODS OF STUDY

In Chap. II it was suggested that as an aid in his thinking the clinician consider three gross aspects of the personality, *viz.*, *motivation*, *capacity*, and *control*. In actual clinical practice, first consideration of *capacity* is often useful. There are several reasons for this, the chief of which is that factors of motivation and control are often obscured by the patient's initial shyness or resistance, and, although these must be overcome in evaluation of mental capacity, the consideration of what the patient can do often acts to build up self-confidence and hence good rapport. Also in many cases the study of capacity serves indirectly to reveal inadequate forms of control. With small children, the use of games—*i.e.*, test materials—at the beginning of clinical study often serves as does nothing else to effect necessary rapport.

Concepts of Capacity and General Intelligence

Among the popular concepts of the function of the clinical psychologist, none has become more entrenched professionally than the idea that he is primarily a "mental tester" and that his primary interest is in the measurement of the I.Q. Many popular and scientific articles have been written about intelligence and the I.Q., and it is certainly not the purpose of this book to make an addition to this literature. However, it is important here to understand what relation intelligence and intelligence tests have to what we have designated as capacity. Several of the tests of capacity, to which reference will be made frequently in this book, are intelligence tests and yield an I.Q. The necessity for obtaining an I.Q. on the basis of any test is not strongly urged in this book, however—at least, it is considered entirely secondary to the evaluation of *various* abilities that the patient may demonstrate.

The term "intelligence," when taken to mean the individual's potentiality for adjustment to the demands of his environment—note the use of the term *potentiality*—is synonymous with what we have

designated as "mental capacity." But it is our belief that to stress the word "intelligence" or even "capacity" too strongly as a single attribute serves to give the term a quality of uniqueness which at least in clinical work is misleading.

Studies of the development of the nervous system in animals during embryonic stages and of the activity of the human fetus and infant show that specific behavior patterns emerge from generalized activity of the whole organism; in other words, from its earliest beginnings, behavior becomes more and more specific. That this is true not only of motor responses but of abilities as well is shown in statistical studies of the results of psychological tests given at various ages (28, 43, 112, 113). In these studies the method of intercorrelation of tests is used. Briefly stated, the coefficient of correlation between tests shows the degree to which those individuals who do well on one test also do well on another. The greater the correlation the more we can infer that the two tests measure the same ability, while to the extent that the correlation coefficient approaches zero we may infer that we are measuring different abilities. Studies at successive age levels show that with increasing age the correlation between tests drops, demonstrating that with age abilities become less alike, and take on the character of greater specificity. Indeed, statistical analyses of correlation coefficients themselves—particularly by means of *factor analysis*—show very beautifully that the multiple abilities of later life develop out of a matrix of few.

Developmental evidence such as this suggests that with increasing age the clinical utility of the concept of general intelligence becomes more questionable. From the clinical point of view, the less child-like the individual—*i.e.*, the greater the general intelligence—the less significant becomes the measurement of intelligence as a diagnostic procedure, and the more significant become measurements of specific abilities. The maladjustment of a ten-year-old child as well as a mentally deficient adult may depend to a great extent on general intelligence; the maladjustment of a college graduate will not depend intellectually on deficiency in general intelligence, for of this he obviously has an abundance. It will depend intellectually on disparity between or deficiencies in specific intellectual abilities.

This is not to criticize the use of a single score for intelligence in some situations, however, such as in the schoolroom or in industry, where rough classification is sometimes necessary. Particularly if it

indicates more than adequate capacity, and if we can be sure it is the result of maximum effort, a rough score of intelligence is often useful in clinical work. But in the majority of clinical cases, we are interested not so much in a score of total capacity for adjustment as in the differential array of performance in a variety of test situations.

Evaluating Capacity from the Case History

Frequently the clinician is able to satisfy himself regarding the capacity of the patient from facts provided in the case history. A well-taken case history may be sufficient to establish that the individual's mental capacity is more than adequate for adjustment to the demands of his environment and to suggest that sources making for maladjustment must be sought in other aspects of the personality or situation.

Of particular importance in evaluating capacity from the case history is the evidence regarding school progress and work adjustment. It is a well-known fact that many tests of intelligence are constructed and standardized in terms of the accuracy with which they measure and hence can predict school progress. In a very general sense, assuming schools of average quality, it may be stated that uninterrupted progress through the elementary grades is evidence of at least average mental capacity—I.Q., let us say, of 90 to 110; graduation from high school, an I.Q. of 120 or better, while graduation from college probably indicates 130 or better. But this generalization is very tenuous, for there are instances of amazingly regular school progress even through high school of individuals whose maximum test I.Q. is 75. Unless the clinician can assure himself that the quality of school standards is at least average and that teachers have been impartial in promoting the patient, such assumption is dangerous.

In older individuals much valuable evidence of capacity is shown in the demonstration in school or hobbies of particular skills or abilities. Most educational programs stress a generalized education for all children through the elementary grades so that, until these are completed, individual skills are not obviously apparent in the school history. But by the time the high-school years are reached, some decision usually has been made regarding the individual's adequacy for further academic study or for vocational specialization. Vocational education—*i.e.*, placement in vocational school following the elementary grades—may have been an economic alternative, but

more often than not it is an expression of apparent limitation in the academic-type intelligence and because of the fact that other abilities have emerged as more salient.

Evidence of skill and abilities is also revealed in the job history. In evaluating the patient's history for evidence of capacity, it is always well to keep in mind the fact that interests and skills go hand in hand in a very real sense. As he develops the child tends to prefer activities in which he is successful—*i.e.*, achieves the greatest ego satisfaction. The consequence of this is that he tends to practice most of these skills and hence to fortify his position, while he tends to discount and therefore neglect those at which he makes a poor exhibition. In later life, vocational choices and successes or rejections and failures are to a great extent conditioned by this early ego drive.

Although earnings are no certain criterion of occupational success and hence skill, they provide a very rough primary index. Of much greater significance is material regarding the individual's advancement in relation to his skills and the reason for changes in employment. Have job changes been in the nature of advancement, or are they signs of impermanence and dissatisfaction and even lack of skill?

History material may provide in a few cases all that is needed of evidence for the capacity of the patient to adjust to the circumstances of his environment. This could be true only on the basis of accurate evidence checked carefully with the patient, and in most instances the clinician will want to verify his opinion by using at least a brief intelligence test.

Evaluating Capacity from Clinical Observation

Sheer observation of the patient in the clinical situation is a procedure that obviously one cannot avoid in any clinical contact, but it deserves to be stressed as a separate procedure apart from those of interview and test, since it is such an extremely important phase of clinical study and one that is often neglected in the stress on more verbal techniques of study. Indeed, in the study of children, uncontrolled observation often yields the greatest single source of understanding not only of capacity but of all phases of the child personality. Such tests of infant capacity as those which have been developed by Bayley (11), Cattell (27), Gesell (44), and Shirley (129) are essentially attempts to standardize the observation of routine

daily behavior. Their emphasis on the age of acquisition of normal behavioral characteristics such as crawling, urinary retention, walking, reaching, grasping, and manipulation serves to show that at early age levels an important criterion of the emergence of capacity to adjust to the environment is the development of motor control.

In observing the patient for evidence of capacity, the clinician may ask himself in the first place: Does the patient show common sense in his judgments? Does he appear planful? Are his manipulations such that they actually lead toward the apparent goal, or are they wasted motion—random and inefficient?

Is the patient alert and responsive? Is he quick to see the implications of the situation for himself and to capitalize on them for his own good? Or is he apathetic, disinterested, dull, and lethargic?

Does he appear to understand his own limitations or assets and behave as if he understood himself? Is the sequence of his uninhibited behavior logical? Does it follow an understandable pattern, or is it suddenly impulsive, suddenly changed with shifts in attention, and as suddenly diverted?

Keeping in mind at all times his observation of other individuals of like age, the clinician is able to classify the patient roughly as retarded or advanced or on a par in his capacity for adjustment, and, where he sees unusual demonstrations of dullness or of hyperexcitability or of poor judgment, he finds reason for more controlled observation or experiment.

Evaluating Capacity from Interview and Conversation

The emergence of language and verbal behavior in childhood is highly correlated with the development of intelligence as measured by most existing intelligence tests and hence correlated with capacity for adjustment. Our environment is itself highly verbal, and adjustment at all phases of life is a function in great measure of the successful use of language. In evaluating capacity in childhood, verbal indices such as earliest use of words and of sentences and the total vocabulary at all ages are important.

The clinician is careful to note the choice of words, the grammar or sentence structure of the patient's speech. Among characteristics revealed in the interview are impressions of the patient's general store of information, the logic of his thought, his reasoning ability, and his ability to make himself understood. The interview may be adapted to cover the same areas of behavior as were considered

important in observation of the patient, *viz.*, the degree of alertness, planfulness, insight, and logic of thought.

Evaluating Capacity by Means of Tests

The history of clinical observation both in medicine and in psychology reveals a steady trend toward objectification of study, a trend originating in the clinician's constant dissatisfaction with clinical impressions and his persistent urge to verify these impressions. Growing out of laboratory psychology, the earliest tests of psychological functions—tests of reaction time—were not developed primarily for clinical use, but early results showed that people differed very widely from one another in this function and suggested that since this was true, such measurements might be useful clinically.

In the sense of clinical psychological tests today, the earliest developed tests of mental capacity were those of Binet (17). Binet was a laboratory psychologist who sought to devise test situations that could be held constant and the response to which could be compared with those of comparable individuals. His objective was to bring together a group or battery of such tests that would differentiate the dull from the bright children and act as an aid in school placement. Since his objective was to obtain measurements for each child to aid in proper disposition, Binet was in essence a clinician.

Binet's original tests were prototypes for many later scales and have themselves been used in revised forms up to the present day. In one important respect Binet's objective differed from one objective of many later developers of tests. Binet sought to measure specific psychological functions, which were defined at least in his own mind. He did not emphasize general intelligence. The fact that a summation of his various measurements yielded a single index of what later came to be called intelligence was a fortuitous development. Many of the tests patterned after Binet's in measuring a variety of abilities were developed for the purpose of measuring the single variable, intelligence, the most frequent criterion for which was the ability to get through school. The consequence of this was that most intelligence tests today represent conglomerates of tests—or subtests—of a variety of psychological functions, all of which have, in a vague and ill-defined sense, some relationship to capacity. To the clinician the pattern of performance on these subtests is usually of more significance than is the unifying score representing

the summation. For this reason he is frequently inclined to minimize the importance of the I.Q., for example, and emphasize in his clinical picture of the patient an ability such as verbal or arithmetic facility.

General Procedure in Test Administration

The purpose in using any psychological test is to obtain a more accurate evaluation of behavior or personality than is obtained by observation and clinical impression. The principle underlying the psychological test is that a controlled stimulus situation is provided for the testee and that his response in this situation can be evaluated with reasonable objectivity and hence rendered comparable to other such response of the patient or of others comparable to him in age, sex, etc.

No psychological tests are foolproof. Careful studies of the consistency of test results show that when any test is repeated there is almost always a change in score and that frequently there may be a large increase or decrease. To the extent that a given test is consistent in repeated use it is called *reliable.* The statistical expression of reliability is the *coefficient of reliability;* this represents the degree of correlation between repeated use or between two forms or between parts of the same test. Coefficients of .85 or larger indicate reasonable reliability. It might be added that there are many tests of low reliability that afford added insights to the clinician in particular situations.

Reliability is greatly increased by the exercise of care in the administration of the test. Factors such as clarity of instructions, optimum conditions for work (such as visibility for visual materials), and a general atmosphere of relaxation for the patient are all of importance. But the greatest single source of error in psychological testing of capacity is in the possibility of failure to initiate and maintain maximum motivation. It is only too apparent in many instances of test usage that maximum effort is questionable. A good principle for the clinician always to keep in mind is that on any test of capacity, although a good score is a sign of capacity, a poor score does not necessarily indicate lack of capacity; it *may* be the result of failure to understand directions, or distraction, or poor motivation, or even deliberately poor performance for some ulterior purpose. During the war, it was frequently found that sailors in boot camp, impatient to go to sea, tried deliberately to make poor scores on

their classification tests because they understood that good scores meant that they would be kept ashore for further schooling.

Many group tests (measures that may be used in testing more than one individual at the same time) are designed so that sources of error are minimized and often show therefore considerable reliability. The chief source of error, however—motivation of the testee—is often unavoidable in a group situation. For this reason, the individual clinical situation affords greater reliability. Individual administration of tests of capacity permits the tester to take into account the testee's particular attitude toward the test and to utilize all the means available to establish the optimal rapport.

One point of disagreement among clinicians deserves to be mentioned here. Having established in the patient optimal motivation for performance, what further concessions should be made to his individuality in administering the test? Should the language used in instructing the patient be adapted to his level (say that of a small child, if necessary), or should verbal instructions, for example, be given from patient to patient with consistent diction and accent? The answer to this question involves much discussion of the purpose of the particular clinical examination and the use to which the results are to be put. Probably the best attitude for the student to take on this question is that assuming optimal motivation the scientific reliability of the results of the test is a function of the preservation of all controls maintained in its standardization. In other words, without boring, annoying, or mystifying the patient, follow the procedure recommended by the author of the test.

Selection of the Test to Be Used

Having decided to verify the impressions gained from the case history and interview, the clinician must now decide what test to use. In many clinics certain test procedures are routine, such as a measurement of the I.Q. It is possible that in some situations—as, for example, a school clinic dealing principally with cases of educational retardation—the routine use of particular tests is administratively advisable. But it is the antithesis of clinical procedure to place full reliance on any given form of procedure, for the stages of clinical study must always be adapted to the problem at hand. Time for clinical study is almost never allowed in abundance. When from interview and school history it can be ascertained in a

few minutes that the child is of better than average mental capacity, it is a wasteful procedure for the clinician to spend a precious hour administering the Stanford Revision of the Binet; the hour might be spent much more profitably in using tests of special abilities or of attitudes or interests or even in further interview with no tests at all.

To aid in selecting the proper test to use, the following factors are of importance:

1. What do you wish to measure? Most tests are purported to be tests of *something*—general intelligence or reading errors or aptitude for medical sciences, etc.—and, further, have acquired in the clinician's experience a particular value in measuring significant characteristics. The test that measures well the characteristic it is supposed to measure is considered *valid; validity* of a test is expressed in the degree to which it is correlated with a measure of the function it is used to predict. Thus, a test of skill in motor-car driving is valid if really good drivers make good scores and really poor drivers make poor scores. Because the Stanford Revision of the Binet Scale is well correlated with it, the test is a valid predictor of school progress. Information regarding validity is sometimes presented in the literature dealing with a test, and it is up to the clinician to familiarize himself with this literature. But occasionally this information is vague or exaggerated, and certain needed facts may not be provided. Clinical evidence that success on the test is definitely related with important aspects of the personality is for the clinician perhaps the best evidence of validity. In any event, actual clinical experience with the test, if only to try it out, provides the best argument for its use or disuse.

2. Does the patient show special personal limitations that indicate that a particular test would be inappropriate? Age is an important factor here. Obviously, we need different test materials to measure motor manipulation of a child of four than we would that of a college freshman. Besides age, factors such as language handicap, reading disability, deafness, etc., are important limiting characteristics and require the clinician to vary his usual test procedures.

3. In some instances a particular test procedure is ruled out because the patient has recently used identical test materials and would therefore achieve a spuriously good score—called "practice effect." Although this is rarely the case, its possibility is always an important consideration.

4. In the previous section, *reliability* of the test was discussed. As with *validity*, facts concerning reliability of a given test can in some measure be gained from the literature, but the best guarantee of reliability will develop from the clinician's experience in repeated use.

5. There are always practical factors that suggest alternatives in test selection. The clinician never has too much time. Consequently he wishes the test to measure as accurately as possible the desired characteristics and in the shortest possible time. Depending on factors of age, education, and particularly reading ability, certain test materials may be used with great efficiency. These are the *paper-and-pencil* tests, most of which are adapted for group use, but any one of which can be used individually. Where these cannot be used or where they need supplementation, tests may be necessary that require the personal item-by-item administration of the clinician. These require more time on his part. In later chapters of this book, particularly in the case studies, the reader will see examples of the way tests were selected and should find implicit in the nature of the study the reasons for the selection.

Tests of Capacity in Common Clinical Use

Work in the construction, development, refinement, and revision of psychological tests takes place constantly, so that there are thousands of tests and forms of tests for measuring many aspects of the personality. Some tests used as little as 10 years ago are now out of date or are so revised that it is questionable whether they measure the same thing and are the same test. Consequently, there are no test procedures that can be considered classic.

In clinical practice, within broad limits, however, certain test procedures have been found so useful generally that they may be recommended at least in outline. It is not the function of this book to go in detail into the nature of the tests. Hence, in this brief discussion, the student is referred at the appropriate points to the most recent sources regarding test instructions, reliability, validity, and so forth.

1. The Binet Scale. With its various revisions the most widely used single test of capacity in clinical practice is that of Binet. The most recent revision (137), that of Terman and Merrill in 1937, is a measure of general intelligence. This revision is designed for use from the age of two years through the level of the superior adult; score may be expressed as mental age, which when calculated with

chronological age yields the intelligence quotient. The test requires about one hour. In using the Revised Stanford-Binet Scale of Terman and Merrill, it is imperative that the examiner follow closely the guide for administration.

Under its present standardization, only one score of capacity is provided by the Binet—that denoting general intelligence. This score is based on the patient's responses in a great variety of situations and with varying materials, ranging from bead stringing to vocabulary and from repeating series of digits to the solving of difficult problems. As shown by low intercorrelation of the various subtests, particularly at the older age levels, this scale in measuring general intelligence also measures many different abilities. The single scores of these different abilities are not readily expressible, however. It is recommended that an independent score for vocabulary in particular be expressed apart from the total score. At younger age levels—let us say up to the tenth year—the test is an excellent measure of capacity, particularly as it is implied in school adjustment and progress. Administration of the Binet is usually and certainly should be stressed in any college course in psychological testing.

2. The Wechsler-Bellevue (or the Army Wechsler) Scale. This scale (143) (and its Army revision) has much in common with the Stanford-Binet: it is administered personally by the examiner, it requires usually about one hour, and it yields a measure of general intelligence that may be expressed in terms of mental age and intelligence quotient. Unlike the Binet, it provides some means of revealing more discriminating measures of subtest performance, in that it is possible to calculate a verbal score and a nonverbal score and to express these also in terms of M.A. and I.Q. This is of distinct advantage in cases where verbal facility may be involved or impaired and hence may be an invalid sign of intelligence, as in cases of reading disability, language handicap, or poor schooling. However, considerably greater insight into the clinical picture is provided by the fact that each subtest has been standardized so that it is possible to determine the variation of each from the norm and hence to obtain a differential picture. The scores provided for this comparison are called "weighted scores". By means of tables these weighted scores can singly be equated to M.A. and I.Q. Although this procedure is not recommended by the author of the test, since he feels that a summation of the test scores is necessary

for reliability, nevertheless, the single score for certain of the tests has high clinical validity and should be examined comparatively in any case.

Of particular clinical utility are the verbal tests of Information, Vocabulary, and Similarities, and the nonverbal test called Block Designs. This last-named test is an adaptation of the original Block Designs test developed by Kohs (82) and used in other test batteries, such as the Arthur Point Scale (5) and the Cornell-Coxe Scale (31), both classified as performance (or largely nonverbal) tests. The Block Designs test is one of the most useful single tests in the clinician's repertory of techniques.

Both the Arthur and Cornell-Coxe scales mentioned above have much in common with the nonverbal Wechsler; they are more exhaustive and possibly more adapted for children. In cases where discrimination between nonverbal assets is important, they may be used efficiently.

3. Goodenough's Drawing a Man. This ingenious test (50) involves simply the instruction that the patient draw a man; it provides a score based on the inclusion of detail and the refinement of drawing characteristic of age. The author claims fairly high correlation between results of this test and results of the Stanford Revision of the Binet. Because of the intrinsic interest to the patient, especially the child, because of the ease of administration, and because aspects of the personality other than capacity are revealed by drawings, it is of especial clinical value.

4. Healy Pictorial Completion Test II. One of the older psychological tests, this procedure (60) requires that the patient determine what is missing in each of a sequence of pictures showing the "Boy's Day at School" and that he select an appropriate completion piece from a multiplicity provided. Almost always of interest to the patient, the test requires fifteen minutes or less and provides an excellent nonverbal index of capacity, particularly of problem solving in real-life situations. In addition, as will be discussed in later chapters, aspects of the personality other than capacity are often revealed in bizarre choices, the logic of choice, and the manner of dealing with the problem.

5. Tests of Conceptual Facility. In evaluating capacity, particularly with the possibility of psychological deficit in mind, the manner in which the patient shifts easily from one abstract concept to another is of considerable significance. The individual suffering

from injury to the brain itself seems to find greater difficulty in dealing with problems requiring him to deduce and apply some general principle. We shall see that of the Wechsler battery the Block Designs in particular offer great difficulty to the patient suffering brain damage, largely because in the visual-spatial area they require the patient primarily to operate with the concepts of at least two characteristics of the block surfaces—rectangular and diagonal areas of color. No matter how much trial and error is involved, the patient who fails to realize that by combining the diagonals he can make solid color figures fails the test. And the series of designs is arranged so that the shift from solidity to diagonality is involved with each new situation.

A useful test of conceptual facility and flexibility is that developed by Shipley (the Shipley-Hartford Retreat Scale, 128).[1] This is a paper-and-pencil test, the abstraction part of which is as follows:

Complete the following. Each dash (_) calls for either a number or a letter to be filled in. Every line is a separate item. Take the items in order, but don't spend too much time on any one.

start here

(1) 1 2 3 4 5 _
(2) white black short long down _ _
(3) AB BC CD D _
(4) Z Y X W V U _
(5) 1 2 3 2 1 2 3 4 3 2 3 4 5 4 3 4 5 6 _ _
(6) NE/SW SE/NW E/W N/_
(7) escape scape cape _ _ _
(8) oh ho rat tar mood _ _ _ _
(9) A Z B Y C X D _
(10) tot tot bard drab 537 _ _ _
(11) mist is wasp as pint in tonc _ _
(12) 57326 73265 32657 26573 _ _ _ _ _
(13) knit in spud up both to stay _ _
(14) Scotland landscape scapegoat _ _ _ _cc
(15) surgeon 1234567 snore 17635 rogue _ _ _ _ _
(16) tam tan rib rid rat raw hip _ _ _
(17) tar pitch throw saloon bar rod fee tip end plank _ _ _ _ _ meals
(18) 3124 82 73 154 46 13_
(19) lag leg pen pin big bog rob _ _ _
(20) two w four r one o three _

[1] Reprinted by permission of the Neuropsychiatric Institute of the Hartford Retreat, copyright owners, Hartford, Conn., 1939.

Of the 20 items, the average adult is correct on between 14 to 20. It is when the subject's score falls lower than his vocabulary score (obtained separately) that his abstraction capacity is considered deficient. Notice that the solution to each problem in the abstraction test requires a concept entirely different from that required for the item preceding it.

The capacity to deduce and utilize abstract concepts is involved in certain tests of classification which have been emphasized within the past few years by several authors (49, 57, 141). Presented in the *Mental Examiner's Handbook* (145) of Wells and Ruesch are five plates each of which depicts objects used roughly in context: kitchen objects, fruits and vegetables, desk objects, tools, and geometrical figures. The fundamental question to the subject concerning each plate is: What are all these things? What is alike about all of them? However, where the patient is at all perplexed or in doubt, further questions are pertinent, for it is important to determine what principles of classification the patient uses. Does he classify according to function, to size, to shape?

Rapaport (110) has emphasized the usefulness of a test similar but composed of real objects, which may be classified in many ways, according to function, color, size, utility, and so forth (the BRL sorting test). A candy cigar, for example, can be placed in a group with another real cigar or with another food item. It is in the ability of the patient not only to make a logical sorting, but to (*a*) explain the principle involved and (*b*) when asked, to deduce a new way of sorting, that he reveals flexibility of conceptual facility. It is this flexibility that, as we shall see later, the patient suffering brain damage tends to lose.

Of several tests which have been designed to test the subject's conceptual facility, one of the most useful is the Vigotsky (141), used extensively and well described by Hanfmann and Kasanin (57). The test materials are blocks, of five different colors, of several shapes. Differing in two ways very clearly (tall-or-short, surface area large-or-small), they may be classified in four groups: tall-broad, tall-narrow, short-broad, and short-narrow. Each of these classes has a name (lag, mur, bik, and cev). The subject is told that the blocks may be classified in four groups, that the group name of each block is printed on the bottom. He is shown a *mur* and asked to place with this *mur* all those like it and sort the remaining blocks into three other piles. Almost invariably the subject will

immediately try to sort by means of color, or shape—concepts that cannot aid in solving the problem. While the healthy individual, realizing sooner or later that neither color nor shape is an aid, will easily try out other ways of classifying the blocks, the organic patient often is unable to discard a principle proved even to him to be inadequate. For even superior individuals the test provides a real task and one in which it is possible for the clinician to "see the wheels go around." Often the subject will need help, which may be given by showing him an error in his *mur* pile and allowing the misclassified block to serve thereby as the example for a second pile. Even though he has been helped throughout the test, it is important to determine not only whether the patient finally can make the correct sorting but to know whether or not he can state the two qualities of the blocks (height and breadth) that essentially classify them into the four groups.

6. Tests of Special Skills and Aptitudes. Depending on the age level of the patient, it is often necessary to utilize tests of special vocational aptitudes, of which there is a tremendous number. None of these will be stressed over others; in this technical and changing field it is essential to keep abreast of recent research and practical results. The same is true of special skills, such as reading, arithmetic, motor skills, musical ability, etc.

One area of particular clinical importance, since it is involved not only in many cases of educational maladjustment but is a vital factor in the actual use of many psychological tests, is the area of reading ability. Of the large number of reading tests, one of the most useful clinically is the Gray Oral Reading Tests (51); this is a series of standardized paragraphs, which the patient is asked to read aloud. The speed of reading as well as the number of errors gives a reading age. Indication of the nature of errors forms a valuable part of the clinical case file.

7. Capacity as Revealed by Projective Techniques. We shall discuss in later chapters two projective techniques in particular that are highly useful in uncovering important aspects of the personality: the Thematic Apperception Test and the Rorschach *Psychodiagnostik*, or Ink Blot Test. The former test consists in the patient's inventing a story to describe the events leading up to the situation portrayed in a picture that the examiner presents to him, and the outcome of the situation. While the themes of these stories often reveal important dynamic factors in the life of the

patient, Masserman and Balken (96) feel that the literary quality of the stories, their naïveté vs. creative invention, and the dearth of imagery vs. the richness of fantasy reveal the deficiency or superiority of the patient's intellectual capacity.

The Rorschach requires that the patient examine a series of 10 ink blots of varying form and color, with the simple question, "What might this be?" Described in detail in later sections of this book, certain aspects of the patient's responses reveal capacity, particularly in the number of forms seen, the use of good form, the amount of movement present, and the logical method of approach. However, on this test the patient is definitely not urged in any way to maximum output, and hence the picture of capacity is often obscured.

CHAPTER VII

APPRAISAL OF CAPACITY—II. INADEQUACIES OF CAPACITY

Aspects of Normal Mental Growth

In order to understand how capacity may be altered it is necessary to review certain characteristics of its normal development.[1] In the previous chapter it was emphasized that mental growth is characterized by an emergence of complexity of abilities from generalized capacity for adjustment. If for the moment we disregard increasing complexity and consider mental growth as a summation of all abilities, the curve for mental growth may be assumed to be something similar to Fig. 2. Here it is apparent that growth is very rapid early in life, that it tapers off during adolescence and is negligible during adulthood. This curve is, of course, somewhat theoretical, for we have no absolute yardstick with which to measure mental growth. However, there is statistical evidence to suggest strongly that test performances follow such a pattern (11, 111, 138), which is similar in shape to the curves for many physical characteristics.

Those who are acquainted with the concept of the intelligence quotient will realize immediately that the curves shown in Fig. 2 are not curves for average mental age. Since the average I.Q. is always 100 and since, therefore, the *average* mental age is equivalent at all points to the chronological age, the average growth in mental age would be represented by a straight line. The ordinate used for the construction of Fig. 2 is not mental age but a variable of absolute mental capacity.

From the curves in Fig. 2, it would have to be assumed that without interruption the mental growth of a given individual follows a regular pattern and that the person who, for example, is most accelerated at age five will also reach the highest adult level. Such a proposition is valid only if we could assume that growth will be uninterrupted, and this we can never do for any given individual.

[1] A good general reference for the subject of mental growth is Stoddard's *The Meaning of Intelligence* (133).

But because there is a high degree of correlation between test scores at various age levels we can assume that for most people mental growth is relatively constant.

If we consider the increase in amount not only of capacity but also of complexity, we might picture its growth in the manner illustrated by Fig. 3. In this theoretical illustration the early generalized

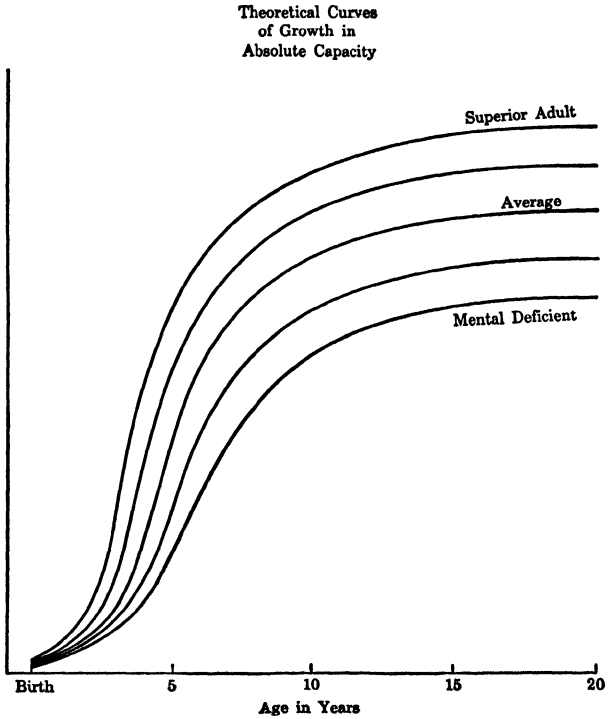

FIG. 2.—Theoretical curves of growth in absolute capacity.

capacity for adjustment is represented by black shading, which in the course of development is maintained with age as a relatively less dominant core in the picture of total capacity and replaced by increasing fractionation, representing the emerging importance of relatively discrete abilities (43, 112, 113).

Here it will be seen that in the superior individual not only is there a greater endowment of total capacity but greater fractionation has occurred. The total mental capacity of the least developed individual is represented as still largely undifferentiated.

Though these two ways of describing mental growth are not necessarily inconsistent, the second approach better illustrates factors of great importance in the following discussion of interruptions of the mental growth process.

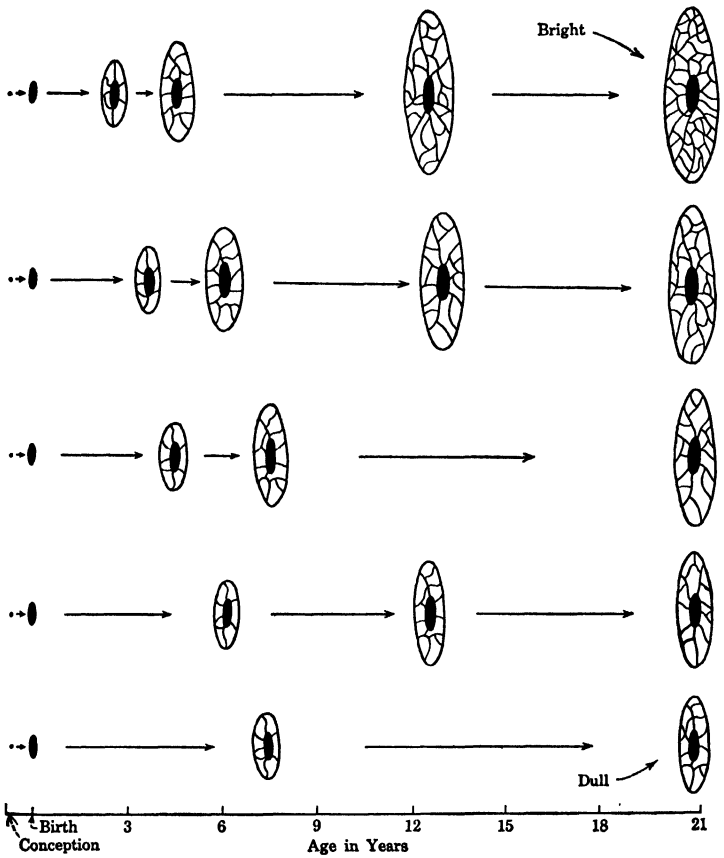

FIG. 3.—Diagram designed to show increasing complexity of capacity with increasing age.

MECHANISMS BY WHICH CAPACITY IS AFFECTED

Influences at any stage in life may result in fluctuation of capacity. It is obvious that one fluctuation is in the direction of increase in capacity with age during childhood. Within the past few years there have appeared several studies dealing with the possibility that, par-

ticularly during the nursery-school years between two and five, the I.Q. may increase. Although this possibility has not been established as fact, it is certainly true that where maladjustment appears to be an expression primarily of inadequate capacity (mental deficiency), the utilization of individualized techniques of training and education has improved general adjustment.

It is with the downward rather than with the upward fluctuations of capacity that the clinician is primarily concerned; maladjustment is rarely due primarily to a superabundance of capacity. There are many factors that account for inadequacies of capacity, but all may be grouped generally under two headings: factors that *limit* its development and factors that *reduce* capacity. These two possibilities will be discussed in the following sections.

Limitation in the Development of Capacity

Heredity. It has been suggested above that in the normal uninterrupted growth of capacity the individual curve tends to follow a rather constant pattern, and it was further suggested that in general the individual retarded early in life tends to arrive at a lower capacity level in adulthood. Thus from birth and even from conception there is a tendency for the individual to preserve a constant position relative to the group. Because of this fact and because there is a tendency for dullness or brightness to run in families, it was maintained for years in traditional psychological teaching that this consistent growth curve was a product of *heredity*. Indeed, in explaining not only dullness but many other forms of maladjustment, there is a persistent tendency throughout psychopathology to look for hereditary factors. When scientists examined critically much of the evidence that the I.Q. was hereditary, it became more and more clear that its tendency to run in families could be referable, at least in part, to the effect of environment. So far as intellectual stimulation is concerned, families tend to perpetuate a rather consistent environment, which in turn might be both the expression of the generations of parents' capacity and an influence (if any) on the child's mental development. Indeed, it was frequently demonstrated that children of parents of lower capacity level when reared in homes more stimulating than their own often developed a greater capacity level than that of the true parents.

This is not to urge in any sense that hereditary factors are not important, for there is much well-founded evidence to prove that

they are. Twins with entirely comparable heredity—called "uniovular twins"—when reared in quite differing home environments develop very similar personalities, and prominent among the identical characteristics shown is the evidence of similar capacity level.

To the clinician the important thing is to avoid at any cost the prejudice against the possibility that environmental factors might be of utmost importance in the development of capacity. Although suggesting that radical improvement in capacity is always *unlikely*, the consistency of individual mental development may be considered to be the result of both heredity and environment, and, since there is always room for improvement of the environment, there is always the possibility for improving capacity.

The Congenital Rather than Hereditary Concept. In recent years it has become customary to emphasize less the hereditary explanation of retardation than the possibility of *congenital* factors, which may or may not include faulty heredity. Although today only partially understood, there are during fetal development many influences that affect psychological growth in such a way as to prevent the development of capacity. One severe limitation is characterized by *Mongolism*. In the extreme the Mongolian is quite unable to adjust to the demands of life, and he is considered, therefore, an idiot. There are physical characteristics that accompany Mongolism, notably an unusual face, which gives the condition its name. There may be unusual ridges on the tongue. The Mongolian personally is likely to be pleasant, affable, and tractable; in institutions for mental deficients Mongolians often become favorites. Particularly susceptible to pneumonia, they frequently die in childhood.

Endocrine disorders early in life sometimes limit the future development of capacity. While Mongolism may or may not be an endocrine disorder, two effects known to be endocrinological are *cretinism* and *pituitary dysfunction*, each of which may be so severe as to express itself in mental deficiency. Primarily a disorder of thyroid function, cretinism occurs presumably because of deficient iodine supply to the fetus or infant and is found only in certain iodine-poor areas of the world. Very rarely is it found in the United States. The form of hyperpituitarism revealed in physical characteristics that in later life may be given the name *acromegaly* (evidenced by overgrowth of the hands and feet, of the lower jaw, and often of the whole body) is not necessarily characterized by mental deficiency, but mental defect in such cases is not rare.

These rather specialized forms of congenital retardation of capacity development are important to the clinician not so much because they are frequently encountered as because they illustrate how mental growth may be limited extremely by prenatal and early physiological factors.

In cases of *physical handicap*, such as deficiency in visual or auditory acuity, or in paralysis or speech disturbance, the development of capacity may be so distorted or obscured that it *appears* limited by such handicap. Most tests of capacity actually measure the degree to which the individual has profited from or capitalized on his environment, the environment being that usual for most persons. It is apparent, then, that in an environment which is specialized or restricted—as would be the situation for a bedridden child, for example—learning will be unusual and specialized, and might as reflected in the test picture be misinterpreted as a deficiency in capacity.

A special case of this artifactual limitation of capacity development through handicap is shown in certain cases of reading disabilities. Capacity itself as functional in human society is to a great extent an expression of verbal experience and most tests of capacity are at least to some extent verbal. The child with a verbal deficiency of any sort may, because of this special deficiency, reveal distorted capacity; he may, however, be a poor reader because the impact of his environment is greatly reduced or highly specialized. As if to compensate for handicap, many children with physical disabilities develop specialized skills, evidence of which indicates without question that physical handicap is not necessarily limiting to the development of capacity.

Mental Deficiency or Feeble-mindedness. At this point it is appropriate to discuss in some detail the extremity of mental retardation known as "mental deficiency" or "feeble-mindedness." These synonymous terms are reserved for retardation which is so severe as to prevent successful adjustment to the environment under any practicable conditions. Either at home or in institutions, mental deficients require attention and care.

There is no fixed level of capacity below which an individual is considered a mental deficient. During the war, it was considered probable that a recruit whose mental age was less than 10 years possessed inadequate capacity for adjustment to naval service. However, many recruits disqualified for naval service because of

this evidence had previously made an apparent adjustment to the environment of their homes; many had earned a living and even supported a family. Thus, in using the concept of mental deficiency it is of utmost importance to consider the environment to which the individual is expected to adjust.

To characterize degree of intellectual retardation certain subclassifications of mental deficiency are frequently used, *viz.*, *moron*, *imbecile*, and *idiot*. Socially, the moron may be considered to be incapable of adjustment except under highly favorable conditions. Because he is considered to have sufficient capacity to be responsible for his own behavior, he is not classified as an imbecile. The imbecile, lacking this degree of capacity, is nevertheless expected to maintain his personal life satisfactorily; under custody, he can be expected to follow successfully the daily routines of living such as eating, toilet procedures, and so on. Many imbeciles may be taught the skills necessary for routine chores such as sweeping the floor. The idiot requires constant custodial care and in extreme cases must have all his wants supplied.

Mental age levels to distinguish these grades of mental deficiency have been suggested as about seven years for the border between moron and imbecile, and about four years for that between imbecile and idiot. Such limits are entirely arbitrary and of little significance clinically. They may be important in institutional placement. The following case from Louttit (94) illustrates the test responses (on the 1916 Stanford-Binet) of a high-grade moron.[1]

C. B., female, C.A. 12-2. In ungraded group in school in which she is doing primary work. Binet M.A. 6-8, IQ 55. The exact order of presentation of the Binet items and the girl's responses were as follows:

IX, 1. (Date) —"Wednesday, June, 1934." (Correct: Wednesday, November 14, 1934.)

VIII, 2. (Counting backwards)—20, 19, 18, 17, 16, 15, 16, 14, 15, 16, 17, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1,

IX, 3. (Making change) —(*a*) 4 from 10, "five cents."
(*b*) 4 from 25, "twenty-five cents."

VIII, 3. (Comprehension) —(*a*) "Pay back."
(*b*) "Run."

[1] Reprinted with permission of Harper & Brothers from *Clinical Psychology*, by C. M. Louttit.

IX, 5. (Making sentences of three given words)—(*a*) (Boy, river, ball, "I have a dog." Directions were repeated. "I have a ball." Directions again repeated. No response. Examiner demonstrates.
(*b*) (Work, money, men) "The men do work."

VIII, 5. (Definitions)—(*a*) Balloon. "Play with it."
(*b*) Tiger. "A great big."
(*c*) Football. "Play with it."

VII, 2. (Pictures)—(*a*) "House, little girl crying, woman sitting in chair, cat asleep."
(*b*) "Boat in the water, men driving it, man helping push, man and woman."

VII, 5. (Differences)—(*a*) "Fly is little and butterfly is big."
(*b*) "Stone is wood and egg is glass."
(*c*) "Glass is glass and wood is wood."

IX, Alt. 1 (Months)—"June, July, August, September, November, December, August, November, December."

IX, 6. (Rhymes)—(*a*) (day.) "Today, may, may, no I got that." (Time limit up.)
(*b*) (mill.) "Mill, nil." (Time limit up.)

(Digits forward)—(641) "641"
(4739) "4739"
(31759) "3759"
(42835) "4285"
(98176) "8916"

VIII, 4. (Similarities)—(*a*) (Wood and coal.) "Burn the same."
(*b*) (Apple and peach.) "Apple tastes different and peach tastes different."
(*c*) (Iron and silver.) "Iron is iron and silver is silver."

VI, 6. (Repeat sentences)—(*a*) "We are having a good time. They are a mouse in the trap."
(*b*) "Walter did have a fine time on vacation time. He went fishing every time."

(Digits backwards)—(283) "382"
(6528) "6528"
(4937) "4937"
(8629) "629"

VI, 4. (Comprehension)—(*a*) "Run, bring umbrella."
(*b*) "Run out, call fireman."

VI, 5. (Knowing coins)—"Nickel, penny, quarter, dime."

The other three tests of year VI—right and left, omissions. and counting—she successfully passed.

(Vocabulary)—(1. gown.) "You wear."
(2. tap.) "Wear on your head." Examiner gave word again. "You dance in."
(3. scorch.) "Scorch your clothes."
(4. puddle.) "Water."
(5. envelope.) "Put letters in."
(6. rule.) "Not talk."
(7. health.) "You eat thing and make you health."
(8. eyelash.) Pointed to eyebrow.
Did not know the next five words. (Pages 112–114.)

Concept of Retardation as Mental Immaturity. In our thinking about mental retardation, particularly in the extremes typified by mental deficiency, it is pertinent to return to the graphic illustrations in Figs. 2 and 3. Effects on mental development that are such as to eventuate in a limitation of capacity actually depress the curve of mental development so that the retarded individual is comparable mentally to a younger individual. The capacity picture of an adult moron of mental age nine years closely resembles that of an average nine-year-old child. This is not to say that the two are identical because obviously the factors of age and experience have had some effect. Nevertheless, recognition of this pronounced similarity is fundamental for an understanding of the nature of individual differences in intellectual functioning. In Fig. 3 it is shown that the mentality of the nine-year-old is comprised in great part of the factor of general capacity, as illustrated by black shading. At this point, few specific abilities have emerged.

We shall see in the next section and in Chap. XIII that, according to the degree of emergence of specificity of function, sudden accidents, injuries, or disease to the nervous system affect the picture of capacity and that the earlier such insult occurs, the more is generalized capacity affected than are specific abilities. Pure limitations of mental growth occur because of influences brought to bear very early in life, during the period for the most part preceding the emergence of specificity. It is understandable that they are evidenced in the generalized depression of the curve of capacity development, rather than in any curtailing of specific abilities.

Reductions of Capacity

It has been suggested that the capacity output may be severely reduced by illness or accident, and while in later chapters we shall

discuss in some detail the nature of factors that precipitate such reduction, it is important here to consider the ways in which reduction is revealed in the test performance.

The reasoning involved in the argument that psychological test results reveal evidence of mental deterioration or *psychological deficit* is roughly as follows:

All other things being equal, it is reasonable to expect that the individual's performance in one area will approximate in quality his performance in all other areas.

In the adult subject there is normally some variation between test performances; most people are better at some things than at others. This individual psychometric pattern might be the effect of a number of possibilities quite within the normal range, such as (*a*) differing motivation in certain areas and on certain tests, (*b*) reflection of specialized interests and therefore practice and skill on certain tests, (*c*) special handicaps, such as reading disability reflected on all verbal tests.

When this intra-individual variability cannot be explained on such common-sense grounds and is exaggerated we refer to the range of performance as "scatter." When the scatter of performances is so exaggerated that we cannot explain it in terms of normal development, it is considered to be a sign of *psychological deficit.* The term "psychological deficit" is used to refer to deficiency of performance in some areas (in contrast to other areas) of such marked degree that it must be regarded as a reduction from previously better performance.

Naturally the pattern of scatter may be simply an exaggeration of the normal individuality of the individual; because of specialized lack of rapport or interests in certain of the tests (in contrast to others), his lopsidedness may be extreme. In later chapters we shall see that extreme lopsidedness of this sort is in essence schizophrenic; it is an expression not of decreased capacity in the areas of poor performance but of decreased or uneven engagement with the test situation. Before we can assure ourselves that scatter is a sign of true deterioration and not a reflection of the pseudo-deterioration or artifact shown in psychosis, certain aspects of the *nature* of scatter must be examined.

First, in true deterioration the adult patient tends to do poorly on the tests of later acquired abilities and to do relatively better on tests of abilities earlier acquired. In the development of her test of

intellectual deterioration, Babcock (6) stressed the fact that whereas vocabulary is usually retained, the abilities involved in reasoning and abstraction are in true deterioration soonest lost. This was given support in the finding of Jones and Conrad (72) that in the process of aging normal individuals tend to retain longest their capacity in general information and vocabulary. Hence, when the scatter reveals the pattern of good vocabulary in contrast to poor problem solving, true deterioration is suspected. Made the theoretical basis for a number of tests of organic deterioration, notably that of Shipley (128), this finding was emphasized in the development of the Wechsler-Bellevue Scale. Wechsler (143) described the following pattern for organic brain disease.[1]

1. Verbal higher than performance
2. Information: relatively good
3. Comprehension: relatively good
4. Arithmetic: poor
5. Similarities: poor
6. Memory Span: very poor, particularly digits backwards
7. Block Design[2]: very poor

Case O-1	Weighted score	Mental age
Comprehension	12	15-6+
Arithmetic	9	14-6
Information	14	15-6+
Digits	13	15-6+
Similarities	11	15-6+
Verbal	59	15-6+
Picture Arrangement	9	13-0
Picture Completion	8	12-0
Block Design	4	8-6
Object Assembly	1	7-0
Digit Symbol	3	7-0
Performance	25	7-5
Verbal IQ	115	
Performance IQ	74	

[1] Reprinted with permission of the Williams and Wilkins Company, from the *Measurement of Adult Intelligence*, by Wechsler.

[2] Wechsler writes elsewhere (p. 151), "Most diagnostic is their inability to do the Block Design test, which is systematically associated with disturbances in visual motor organization."

8. Object Assembly: poor
9. Digit Symbol: very poor
10. Small variability when verbal and performance test scores are considered separately. (Page 149.)

Two cases from Wechsler (143) illustrate this organic pattern, O-1 and O-2.

Male, age 34, showing definite neurological signs including marked hydrocephalus, facial weakness, slight tremor, absent abdominals. Also suggested Babinsky on left side with mild postural deviations on same side. Diagnosis—post Meningo-encephalitic syndrome. At age of 6 months[1] patient had an injury with sequelae lasting 6 months, which was diagnosed as meningitis. This case shows the four most conspicuous signs of organic brain disease: large discrepancy between Verbal and Performance in favor of the former, very low blocks combined with even lower Object Assembly and very low Digit Symbol. While all the test scores on the verbal part of the examination are average or above, the two lowest are Similarities and Arithmetic, which are in line with the organic picture. The only exception is the digit span, which is good for both forwards (8) and backwards (6).

Case O-2	Weighted score	Mental age
Vocabulary	10	15-6+
Comprehension	11	15-6+
Arithmetic	6	10-6
Information	11	15-6+
Digits	9	14-6
Similarities	7	11-3
Verbal	45	14-6
Picture Arrangement	7	11-1
Picture Completion	10	15-6
Block Design	7	11-1
Object Assembly	11	15-6+
Digit Symbol	4	8-9
Performance	39	11-9
Verbal IQ	103	
Performance IQ	103	

Male, married, age 54, fireman. Entered hospital with complaint of headaches and forgetfulness. History of old skull fracture. Physical

[1] Note how this contradicts our concept that specificity of handicap is an expression of brain injury at later rather than earlier age levels.

examination, including blood-Wasserman and flat plates were negative. While under observation referred by Neurological service for psychometric. On Bellevue Adult patient attained a rating of average intelligence with subtest score distribution as indicated in summary. . . . The distribution shows the following organic signs: Arithmetic—low, Similarities—poor, Blocks—poor, Digit Symbol—very poor. Digit Span appears to be unimpaired, but actually average score of 9 was due primarily to subject's relatively good span for digits forward (7); backwards span was only 4 digits. A very low digit backwards in a person of otherwise normal intelligence is generally characteristic of organic brain disease. This patient, when his age is considered, manifests relatively little deterioration but is of special interest because he shows many of the signs of organic brain disease; the one conspicuous exception is the relatively high Object Assembly score; but a good Object Assembly is occasionally found in organic cases who have not as yet deteriorated markedly. (Pages 157–158.)

With a pattern of this sort in an adult, therefore, particularly when we can be assured of maximum effort, we can suspect true deterioration. A pattern of scatter that is markedly different because it seems to express lack of effort or of engagement in certain tests suggests the psychotic rather than the true deteriorative process.

The following cases from Wechsler illustrate psychotic deterioration:

Case S-1	Weighted score	Mental age
Comprehension	10	15-6+
Arithmetic	10	15-6+
Information	15	15-6+
Digits	14	15-6+
Similarities	11	15-6+
Verbal	60	15-6+
Picture Arrangement	8	12-0
Picture Completion	13	15-6+
Block Design	10	15-11
Object Assembly	12	15-6+
Digit Symbol	4	8-6
Performance	47	14-0
Verbal IQ	116	
Performance IQ	95	

Male, age 41, war veteran, 3 years college. Long history of inadequacy and maladjustment. Has been at various mental hospitals and repeatedly diagnosed as paranoid praecox. Latest admission followed threats of violence to mother. Well preserved, no hallucinations or delusions elicited; but insists that mother and veterans hospitals are against him. Patient is of better than average intelligence. The schizophrenic signs in his psychometric are: Verbal much higher than Performance, low Picture Arrangement, very low Digit Symbol simultaneously with high Digit Span, large discrepancy between Information and general Comprehension in favor of the former. High intertest scatter within Performance group.

Case S-2	Weighted score	Mental age
Comprehension	6	10-6
Arithmetic	6	10-6
Information	10	15-6+
Digits	6	10-6
Similarities	0	7-0
Verbal	28	10-3
Picture Arrangement	4	8-9
Picture Completion	10	15-6
Block Design	0	7-0
Object Assembly	2	7-0
Digit Symbol	2	7-0
Performance	18	7-0

Verbal IQ....83
Performance IQ....71

White, male, age 39, elevator operator. This patient shows marked deterioration, generally seen only in old cases but occasionally also in cases of relatively short duration. In his case, reported onset of disease was about six months prior to administration of test. First indication that something was radically wrong with patient occurred when he left his job with no apparent reason; said he was nervous and had no peace of mind. Later complained police were after him. On admission to hospital was bewildered, kept to himself but was passively cooperative. Although diagnosed as paranoid schizophrenic, general behavior was that of a simple or mixed type. Psychometrically, he showed the following schizophrenic signs: Verbal higher than Performance, low Digit Symbol with much better Digit Span, low Object Assembly, zero scores on Similarities and Block Design, high Information. Most outstanding of all, very large intertest variability ranging from a score of zero to a score

of ten. The very low scores on the Object Assembly and Digit Symbol together with zero score on the Block Design taken alone would suggest organic brain disease, but in that case we would also get a low Picture Completion and not an average score on this test. The inconsistency here is what definitely shows this case to be schizophrenic. Similarly, only a schizophrenic would give an average score on Information and a zero score on Similarities. (Pages 158–159.)

When with evidence of adult psychological deficit it is difficult to reassure oneself that there is or is not an organic basis for it, the Block Designs test is of particular significance. The study of Lidz, Gay, and Tietze (91) emphasizes the finding that while cases of actual cerebral damage showed in their performance on block designs an average decrease of about four years below the vocabulary age, the average difference in a group of schizophrenics was negligible. This certainly does not mean that a score on the Block Designs test that is poor relative to the verbal tests indicates that the patient is not psychotic, for the psychotic patient may be relatively poor on any test—the Block Designs test is no exception. Hence, in cases where the explanation of deficit is in doubt (as to whether it is or is not organic), good relative performance on the Block Designs suggests only that cerebral damage is a less likely possibility.

On classification tests, the differentiation between the organic and psychotic patterns is particularly clear. Whereas on a test such as the Vigotsky the psychotic patient *en rapport* proceeds to classify the blocks in some way, no matter how odd, the organic patient is perplexed by the problem itself, and, if he does deduce and attempt some principle of classification (such as shape or color), he will cling desperately to his principle; he is literally incapable of relinquishing it, even though he may grant that it is not producing the desired result.

The Rorschach, described in greater detail in Chap. X also reveals the puzzlement and complexity characteristic of the organic patient. Typically, such a patient exerts himself tremendously to do well—he peers at the blots intently, gives his responses hesitantly and without confidence. He reveals his sense of inadequacy in his frequent questions—"Is that right?" or "Well, it isn't that exactly, but . . . ," and in introductory phases such as "Well, it doesn't look very much like it, but I would say it was. . . . " Piotrowski (107) has designated this manner of response as "perplexity."

Quite related to perplexity is Piotrowski's "impotence," the inability to change his response even when the patient is himself doubtful of its quality. Together with these ways of reacting to the ink blots are others that, objectively, may be found in any psychopathologic pattern but that are consistent with the organic syndrome—responses that (discussed later) involve color, form, and movement. In a general sense the organic patient gives few responses, he restricts himself to form (*i.e.*, he tends not to use color, texture, etc., in combination with form), and he fails to see the figures in action. All this is evidence that in his eagerness to utilize that which he considered even tentatively to be good, he clutches to it desperately as a means of demonstrating his effectiveness. Not only is the capacity of the organic patient reduced, but also in the patient's eagerness to utilize some means of expression he chooses the least complicated aspect of the blots—form—and hangs on to it desperately.

Reduction of Capacity and Age. Up to this point in the discussion of psychological deficit, we have stressed its demonstration in the adult. The degree to which the scatter of test performances can be considered suggestive of organic deterioration decreases as we retrace the life span. In a careful analysis of the comparison between infantile and adult brain injuries and their expression in test performances, Hebb (61) shows that

> (1) Early lesions will tend to produce low scores in both Binet and performance-test tasks, regarding the Binet as predominantly a level-of-development index, the performance test predominantly as a present-level index. . . .
>
> (3) When the lesion occurs in the middle of the developmental period, or when disfunction occurs then or is of increasing severity during growth (as when epilepsy appears late or is becoming worse)[1] the test score pattern would tend to approach that found in adult deterioration, with Binet and vocabulary indices relatively high. . . .
>
> (4) . . . on the whole there is less disparity in the effect of infant injury on different test scores. (Pages 287–288.)

[1] It is interesting in this connection to reconsider the case of Wechsler, reported on p. 70. This patient revealed at age thirty-four a pattern of typically adult disparity, yet was interpreted in the light of an injury suffered during the first year of life. However, Wechsler reported later (144) that "this would not mean that the 'organic' pattern would necessarily manifest itself at an early age. My own impression is that such signs as did appear were not new but represented a cumulative deteriorative process."

The apparently generalized effect of infant lesions argues for some degree of equipotentiality of the cortex in development. Even verbal abilities, which seem so sharply localized in the speech areas of the adult, have been seen to be dependent on the integrity of the whole cerebrum for their normal development. The peculiarities and selectivity of the effect of late injury make it clear that the functions comprising normal intelligence must be in some sense independent of one another (page 290).

Thus we see that in infancy damage to the brain seems to have a more generalized effect that it does in later childhood and in adult life, at which later stages it is often evidenced by scatter. The infant thus injured is to be considered more a case of general retardation than a case of specialized handicap.

These findings are, of course, entirely consistent with the neurological and behavioral evidence suggested by the studies of Coghill (30), of Lashley (87), and of Irwin (70), on the one hand, and of the factorial studies on the other hand which show consistently the tremendous significance in early life of general intelligence and the decreasing role it plays in the total picture of capacity as development proceeds.

CHAPTER VIII

APPRAISAL OF MOTIVATION—I. METHODS OF STUDY

General Considerations of Motivation

In any murder trial a focal point is reached in the establishment or disproof of the defendant's motive for the crime. If it can be shown that the act was deliberate and premeditated, maximum penalty is awarded. It is in the case where there is no admission and slight proof of guilt that the motive to murder becomes critical, for if it can be shown that murder of the victim would be to the advantage of the accused, a strong psychological point is gained in the argument of the prosecution.

In the court of law, any man is innocent until proven guilty; simply to imply motives for his behavior does not establish guilt. Our objective in clinical examination is a far cry from any desire to establish innocence or guilt, for with these we have no concern. But we are interested profoundly in the motivation of the patient's behavior—not with respect to a single act but with respect to the whole pattern of his daily life and personality. Behind every act or movement or thought may lie factors of utility to the individual, even though so simple as the need to maintain life from one moment to the next. It is the understanding of this very factor of utility to the organism which affords us our greatest insight into personality and the adequacy of adjustment.

Very often a person's stated intention differs widely from his actual motive in behavior. A student, for example, may avoid the course in Geology 3–4 believing himself uninterested in geology. Actually, however, he did well in Geology 1–2 (some sign of interest!). Although it never occurred to him in his avoidance of the course, it happens that the standards for 3–4 are very high, and it is difficult not only to make a good grade but even to pass. Who is to say that his decision because of lack of interest is not an expression at least partially of a desire to steer clear of hard work? Our friend is not a liar; he simply does not understand all the factors behind his decision.

One of Freud's greatest contributions was his emphasis on the significance of accidents, or slips of the tongue, in revealing the true motivation of the individual (40). Such emphasis is to stress the unrealized and unadmitted and hence essentially unconscious motivation of the individual's behavior.

It was emphasized briefly in Chap. II that a generalized motivation for all individuals may be characterized as the drive for ego satisfaction, and that the direction of this drive through acceptable and useful channels forms the essence of successful adjustment. Controls that channel motivation unsuccessfully toward ego satisfaction characterize maladjustment.

It is the purpose of this chapter to discuss in some greater detail the nature of this fundamental motivation to ego satisfaction, in the hope that its unusual forms of expression through inadequacy of control may be better understood. We shall discuss also certain clinical procedures which aid in evaluating the nature and role of motivation in the individual's present adjustment.

One concept which it is important at the outset to evaluate in its proper light is the idea that motivation is a quantitative amount of driving force. Popularly, you will often hear the expression, "He has a lot of push," or "She is an ambitious wench." The implication of course is that the vagabond tramp, being lazy, has little or no motivation. This is to use the concept of motivation in the sense of drive toward achievements that characterize social success—of which the bum, unfortunately, possesses little. Actually, the behavior of the bum is as strongly motivated as that of the tycoon—he has simply acquired or developed or been driven to a different means of satisfying his ego drive. He may be quite as happy.

It is during the period of infancy that we are best able to understand those impulses that form the basis of motivation. In infancy the drive for ego satisfaction and the drive for security are scarcely distinguishable, for each is represented in the dependence of the infant upon the mother. But with the first frustrations—those attendant upon regulation of nursing, soon to be followed by the restrictions of toilet training—aggressive impulses become apparent as the beginnings of a pattern of hostility, a drive that may be considered to be the antithesis of the erotic love impulses.

Development of Sexual Awareness. Much has been written about what is called the "psychosexual development" of the individual and its importance in later development as a determiner of personality.

It is not the purpose of this book to present a detailed discussion of psychosexual development, but the idea cannot be ignored in any consideration of personality development. In Chap. II it was suggested that in the dawning of self-awareness, the physiology—and hence the psychology—of nutrition and elimination are closely interwoven with ego satisfaction and frustration, and it is understandable that throughout life there should be a carry-over of this *gestalt*. For some children and adults the very act of eating is obviously a great source of pleasure even when carried to admitted excess. In the same way, though less obviously perhaps, some persons retain throughout life an exaggerated concern about eliminative functions. These associations between nutritive and eliminative functions on the one hand and ego satisfaction on the other are very apparent not only in the behavior of extremely maladjusted adults but in normal childhood. For the child to express a desire for something to eat at any time is a commonplace thing. He often chews paper, eats dirt, bites his fingernails, or sucks his thumb. As he grows older we expect him to become more refined in his tastes, but we find even in adults, particularly under stress, traces of such eating-like behavior.

Similarly, we are not shocked by the child's absorption in toilet facts. His conversation makes frequent reference to "weewee." We buy the small girl a doll that will not only take water from a bottle but will void it in the proper area. All of this is quite comprehensible when we realize that so much of the young child's life is itself devoted to these activities, and little else. Little more is expected of the child than that he will eat well and regularly and that his toilet behavior will become regulated.

In his subordinate position in the family circle the child has frequent cause to feel left out or slighted or to feel that he does not receive enough of the spotlight. It is natural then that he should seek occasionally to attract attention to himself. To do this he has few resources, but he has learned early that any violations on his part of the regularity of eating or elimination will certainly bring results. To refuse to eat or to urinate deliberately at an improper time and place will bring attention, even if it be punitive rather than loving. The reward he seeks is the emotional arousal of the parent, whether as anger or affection, for this reassures him as nothing else will of real concern for his welfare, and it therefore represents security. The child's assertion of himself—of his ego—

represents an early form of aggression. As he develops later, he acquires techniques of self-assertion or aggression more specialized, perhaps, but with the same motive: that of asserting and hence reassuring the ego.

The objection may be raised at this point that although this may all be true, there is essentially nothing sexual about it. Nutrition and elimination do not appear to be related necessarily to reproduction. If we consider sex to represent the reproductive function, the relationship is, indeed, rather remote. But between these early nutritive and eliminative experiences on the one hand and the emergence of awareness of sexual differences on the other, there are psychological relationships that serve to initiate an early sexuality even in the infant. This is sexuality not at all in the reproductive sense but sexuality in the sense of subjective awareness of an aspect of the ego, one that receives early emphasis in the child's development. There are several good reasons why in this ego sense the child naturally becomes aware of sex and sexuality.

1. The child is treated early in life as a boy or as a girl. The boy is given pants or trousers, then a haircut, and is soon identified with brothers and father. He early learns that aggressive, dominating qualities are manly; he is expected to play with boys' toys, such as guns and boxing gloves. Little girls are encouraged to acquire the qualities of gentleness and passivity and to identify themselves with sisters and mother.

2. In the child's growing awareness of anatomy it is natural that attention, just as it is centered on hands and feet as they are related to manipulative processes, is often centered on parts involved in physiological processes. In normal infancy those parts of the body associated with nutritive and with eliminative functions early acquire a special valence because of their association with ego satisfaction. Later development is characterized by an emergence of specificity of certain zones of the body as areas of special sensitivity and function in arousing pleasurable sensation of definitely sexual character. These areas are called *erogenous zones* and are limited normally to the areas of the lips, the genital organs, the anus, the buttocks, and, following puberty, the breasts.

3. The growing awareness in infancy of sexual anatomy is followed by an interest in the sexual anatomy of others. The child early detects difference between others and the self. That this comparison early in life is a problem of great interest to very normal children is

shown by the frequency with which they seek opportunity to study one another surreptitiously or otherwise, as necessity demands.

4. An extremely important reason why the young child attaches to sexuality great personal significance is that society surrounds sexuality with a strict taboo, which is brought to bear on the child long before he has the capacity to integrate it successfully into his philosophy of life and which for this reason leaves him in doubt. Consider the transition the child must make from infancy to, let us say, the point at which he goes to the first grade and there must get along successfully with strangers. From an infant nursing at the mother's breast, totally uninhibited in every way, the child must pass through the intimacies of toilet training and of early firsthand sexual observations, experiences that are increasingly frowned upon and often punished, until at six he must learn to disguise his interest in sex. The little girl must remember to keep her skirt modestly down.

One of the strongest taboos that the young child encounters is the taboo regarding self-manipulation of the genital organ, or masturbation. In normal infancy, masturbation is frequent; often it is in the nature of random manipulatory activity—a part of the whole process of experimenting with objects. But because of its erogenous nature, manipulation of the genital organ acquires a special potentiality of satisfaction. Indeed, urination is often pleasurable, in part at least, because it is associated with activity of the external genital organ. It is probable in the development of most children that masturbation is early endowed with the wrongness of pleasure thus aroused, a censure that serves to impress upon the child the fact that such pleasurable activity engenders in others strong emotional reaction, even though one of anger or hostility. Hence, the erotic pleasure aroused by masturbation, like that derived from food and elimination, acquires a social value—one of rejection rather than acceptance, it is true, but social nevertheless.

When in normal development following puberty the individual recognizes potentialities within the self for obvious sexual expression, we often see confusion and conflict similar to that experienced by the young child in situations of sexual frustration. In normal development as well as in psychopathology the sense of guilt attached to pleasure aroused from the genital organs is a frequent source of conflict usually quite unrecognized by the individual. Indeed,

society reinforces this sense of guilt by open censure of masturbation as undesirable, unhealthy, or unclean.

Traumatic Factors in the Development of Sexual Awareness. Today there is much discussion of proper sex education of the child. Very often the program suggested for such education proposes a careful integration of the child's incidental and fortuitous self-education with a healthy explanation of the "facts of life." But too often such proposals are in terms of scientific and impersonal facts quite unrelated to the child's store of knowledge. Sex education is not formal. It occurs as a part of growing up. We hear occasionally of a boy or girl approaching maturity without any knowledge whatsoever of where babies come from, as if such ignorance were tantamount to an ignorance of sex. Any individual approaching maturity possesses an intense awareness of sexuality, acquired—perhaps painfully and confusingly—from attempts to understand words written on toilet walls or from sudden exposure to outright sexual behavior. In the life of the young child as well as of the adolescent, sudden revelations of sexuality often occur before the achievement of an emotional maturity adequate to integrate these experiences into his attitude toward life, and he is left miserable and alone. It is important in this connection to realize that, as with masturbation, so with other normal sexual activities, such as intercourse and childbirth, first experiences are usually painful and emotionally intense with satisfaction a remote and doubtful outcome.

Sudden revelations of sexuality to the child are often important in casting his future attitudes toward sex and, even more importantly, in arousing unrecognized conflicts and confusion that are basic to unsuccessful adjustment. Often but partially understood, these sudden revelations, because of their very vagueness, are to the child a source of puzzlement and confusion. Again, an experience may be clear and sharp and intensely shocking—an experience of revulsion and horror. Always of emotional significance, these experiences may be basic to conflict and worry and anxiety, not only immediately, but for life.

Association of Erotic and Aggressive Impulses. It is natural in our society for the child as he acquires the concept of differences between male and female to associate aggressiveness and dominance with masculinity and passiveness and submission with femininity. Through observation of incidental demonstrations of affection between parents or other adults this concept is reinforced in such

a way that sexual behavior seems somehow to be an expression of aggressive attack. This identification of aggression with the sexual role of the male is revealed in many aspects of normal social life, such as in the custom of the man leading in dancing. In the consideration of fantasy and its relation to the personality, we shall see how this traditional concept of the male as the aggressor is basic to many forms of expression that characterize unsuccessful adjustment.

Elaborations of Theory That Serve as Interpretive Hypotheses. The foregoing discussion of the development of motivation should be sufficient to show how the complex revelations of adult motivation are essentially derivatives of the basic drive of the infant for ego satisfaction, that aggressiveness is a natural form of self-assertion, and that it emerges in a setting of association with sexuality. In following chapters we shall find frequent illustrations of these basic impulses in normal as well as unsuccessful adjustment.

There are certain highly elaborated theories based on the foregoing discussion of development and motivation that should be mentioned in passing, however, because the student will find frequent reference to them in psychopathological reading. Like the basic concept of psychosexuality, these theories are elaborations from psychoanalytic thinking.

To the psychoanalyst, psychosexual development is a process of development through stages of sexuality, the first being a stage in which the libido or erotic drive is directed toward the self and for that reason called the *narcissistic* stage. Phases of the narcissistic period are represented by interests in nutrition and the mouth, called the *oral* stage, by interest in elimination or retention of the feces, called the *anal* stage, and by interest in the genitals, called the *genital* stage. As the child acquires increasing awareness of reality, he passes from the narcissistic stage to a stage of interest in and a preference for association with members of the same sex, called the *homosexual* stage. In the emergence of adult sexuality the libido is finally directed toward the opposite sex, and the *heterosexual* stage is finally achieved. In normal adult behavior traces of self-love and love of others of one's own sex are obvious in successful social adjustment. Many forms of unsuccessful social adjustment expressed in exaggerated tendencies toward self-love or homosexuality may be interpreted in the light of unusual experiences of the individual in passing normally through the earlier stages of libidinal interest.

A further refinement of this developmental theory is that in normal

psychosexual development the identification of the boy with the father engenders in the child a feeling of competition for the love of the mother, and that love for the mother has its counterpart in hostility toward the father. In like manner, identifying herself with the mother, the girl recognizes her as a competitor for the love of the father and maintains a hostility toward her. The term "Oedipus complex" has been given to this configuration of love and aggression because mythologically Oedipus married his mother and slew his father. For the female the term "Electra complex" is similarly used.

Such theoretical hypotheses represent attempts to achieve a logic for the developmental period from which avenues of personality development originate. They are still entirely theoretical. Whether they prove to be more than theory will depend on further experimental and clinical study. To many clinicians such hypotheses are entirely too farfetched and unsubstantiated to be plausible, and, because they violate certain fundamental moral principles, they are often resisted emotionally. Nevertheless, in modern psychopathology there is a tendency for psychoanalytic thinking to gain greater credence, for psychoanalytic hypotheses are often startlingly illustrated in case studies of unusual forms of adjustment, a fact that often suggests that they may apply universally.

Clinical Techniques for the Study of Motivation

The clinical study of basic motives to behavior is a procedure of making inferences about what is subtle and hidden from what is obvious and apparent. Only in the case of the very young infant are basic impulses obvious to the observer, for the process of growing up is one of increasing inhibition and modification of impulsive behavior so that it is shaped into socially acceptable channels.

This is not to say that underlying motivational factors are not implicit in overt patterns of behavior. Indeed, it is naturally in overt behavior that the clinician seeks and finds clues as to what lies beneath. The patient's stated aims in life, for example, although never considered to be explanatory of his behavior, are significant in that they reveal both his capacity for self-understanding and the particular forms of inhibition or control that he has developed as his own private pattern of civilization.

Clinical methods for the study of motivational factors range from direct questioning of the patient as to his objectives and ideals to the study of his solution to problems provided for him experi-

mentally. From facts gained through direct questioning, informal observation, tests of interests and attitudes, and tests that require the patient to elaborate personalized projections of himself, the clinician attempts to formulate a theory of developmental motivational dynamics that will account for the patient's present adjustment. Almost always this theorization requires some interpretation of present behavior in terms of environmental influences that early in life were important in shaping the patient's motivation. In this way the clinician attempts to develop for the individual life pattern a theme of personal development so that the psychogenesis of present adjustment may have some logical explanation.

The Patient's Explanation. The adult patient who is at all inclined to introspection and self-analysis can tell the clinician much about his objectives and ideals, and he often gives at least partial explanation of how these developed. Very frequently expressions such as this are encountered: "Well, my interest in music naturally developed because it was encouraged at home; my father was an amateur musician," or "I began running away when I was fourteen because my father came home drunk and was mean to my mother," or "I was the tallest girl in my class all my school life, and I guess that's why I always avoided making speeches—I felt so conspicuous." Though only partially explanatory, such fragmentary attempts at self-analysis are always pertinent, and they often act as a point of departure for further questioning and more penetrating analysis. We shall see in later chapters that a large part of the task of therapy consists of helping the patient to understand himself and accept impulses hitherto considered undesirable. Hence, these early explorations into the patient's theory of his own psychogenesis are a forerunner of the education to readjustment that is psychotherapy.

Occasionally the clinician encounters a patient who is a virtual addict of self-analysis and who will if permitted go on for hours explaining his psyche in great detail. Such a patient often has read widely in psychology and psychiatry. He illustrates forcibly a fact that the clinician must always keep in mind, *i.e.*, that the patient's explanations of his adjustment are always biased and cannot be taken at their face value. The patient's explanations are, indeed, a most significant revelation of the means by which he attempts to excuse those aspects of his personality that to him apparently require justification. Called *rationalization*, this process of finding some

logical excuse for questionable behavior tendencies is one form of control to be discussed in later chapters. Often the patient's rationalization has become so elaborate and systematized that it seems to be the dominant force in the personality picture.

Frequently encountered by the clinician is a patient who because he lacks self-understanding fails entirely to realize that his difficulties in adjustment are the result of anything within himself. The tendency to avoid personal responsibility for one's difficulties and to blame them on the environment is a normal characteristic of children. Dropping a dish while attempting to dry it, my four-year-old son explains, "I didn't drop it, daddy; it fell out of my hand." In adults, such avoidance of personal responsibility for maladjustment is a carry-over from childhood. Avoidance of personal blame is in reality an assertion that guilt must be placed somewhere or on someone. By avoidance of personal responsibility the patient places the blame on factors other than himself—whether it be another person, the weather, or lack of schooling. In this sense, he *projects* his own responsibility or guilt onto others.

It is seen then that the patient's own explanation of his personal psychodynamics is always of interest and significance. Because of errors of bias, it can rarely be accepted as explanatory. Devices such as rationalization and projection serve to disguise even to the patient the real nature of basic motives.

Motivation as Reflected in Interests and Attitudes

It is obvious that by means of interview, observation, and questionnaire the clinician may obtain material of significance in its reflection of motivational factors. A study in the life history of the individual's vocational and educational interests, his hobbies, and the social activities he prefers reveals the cultural direction toward which basic motives are oriented. Hence an analysis of such factors in the case-history material makes it possible to set up preliminary hypotheses that may give body to the life pattern.

A careful study of the patient's interests is highly important, particularly in cases where vocational or educational guidance is needed. Several relatively objective questionnaires have been developed that require the patient to state whether he likes or dislikes a variety of activities and occupations. The results of the questionnaire may be scored and compared with the interest patterns typical of persons successfully engaged in a variety of occupations,

thus indicating so far as interests are concerned the patient's similarity to them and hence suggesting his fitness for particular occupational placement.

One of the best known standardized questionnaires is the inventory developed by Strong (32, 134), which may be scored for a number of occupations. Such inventories of interests, together with tests of aptitudes for various occupations, have wide application in all situations involving vocational guidance and selection. Tests of this type were used extensively by the armed forces during the war.

Methods of Studying Basic Motives. If in the study of motivation we focus our attention on motivational dynamics—*i.e.*, on the means by which he attempts to achieve ego satisfaction and love—there is much in the patient's everyday behavior that is obviously of interpretative significance. Basic drives are immediately apparent in dominant and aggressive behavior, in overeating and other forms of overindulgence. The need for ego satisfaction is clearly revealed in the patient's attempts to draw attention, as in unusual clothes, or in a manifest desire to show off or to perform dramatically, to talk in public, to write articles or books, to drive an expensive car, or to be seen with important people.

Sexual motivation, sometimes revealed in activities the sexual nature of which is obvious, is more frequently disguised and can be inferred only indirectly from other aspects of behavior, such as in play, in art, and in the content of daydreams.

Methods That Attempt to Quantify the Indirect Reflection of Basic Motivations

Certain test techniques, on the surface tests of interests, have been developed for the purpose of getting at basic motivational factors. One test, composed of a variety of items regarding interests and preferences, is the Bernreuter Personality Inventory (15). The patient's answers may be expressed as scores for introversion-extroversion, neuroticism, sociability, and dominance. Another paper-and-pencil measure of dominance is the ascendance-submission scale devised by Allport (3). It is probable that the dominance variable as measured by each of these scales is related to aggressiveness as we have considered it.

The orientation of sexual motivation may also be measured indirectly by the use of questions regarding interests and preferences. In the Terman-Miles Attitude-interest Inventory (136), thus named

intentionally to disguise its real purpose, items were selected for their validity in distinguishing between males and females. This technique of test construction was used also for the Minnesota Multiphasic Personality Inventory (59), a scale that yields a score not only for femininity of interests, but also for variables such as depression, schizophrenia, and hysteria. Indeed, of the techniques that utilize the patient's choice of interests as a means of getting at masculinity-femininity, it has been the author's experience that the Minnesota measure is the most useful clinically. This is partly because the Minnesota scale, unlike others, permits the patient to sort cards and thus makes it possible for the clinician in later interpretation to concentrate his attention on unusual answers only. Further, the card-sorting technique seems to have greater appeal for the patient and serves to preserve a discreteness for each item that may be partly destroyed in inventories like the Bernreuter or the Terman-Miles, which simply list the questions in order.

It is pertinent here to present the 60 questions included in the Minnesota Inventory that yield points toward a score of femininity. Basing their selection of items on results obtained from 117 males and 108 females, the authors of the test, Hathaway and McKinley, found that the average number of feminine answers for normal men was 20 to 21, while women gave an average of 36 to 37 feminine answers. When a man answered as many as 30 or more items in the feminine direction his score was considered suggestive of a tendency toward femininity (only about 2 per cent of men give this number of feminine answers). A woman was considered as deficient in femininity when her score was 27 or less (since only about 2 per cent of women give so few feminine answers).

The items as answered in the feminine direction are as follows:[1]

Considered "True" by the male, "False" by the female

I am very strongly attracted by members of my own sex.
I am worried about sexual matters.
I wish I were not bothered by thoughts about sex.
I like to talk about sex.

Considered "True" by the female, "False" by the male

I have never indulged in unusual sex practices.

[1] Items from the Minnesota Inventory are reprinted here and elsewhere in this book with permission of the University of Minnesota Press; the inventory is distributed by the Psychological Corporation, New York.

Answered by both males and females

True	False
I have often wished I were a girl; (or if you are a girl) I have never been sorry that I am a girl.	My feelings are not easily hurt.
I think that I feel more intensely than most people do.	I was a slow learner at school.
I frequently find myself worrying about something.	I frequently find it necessary to stand up for what I think is right.
Some of my family have habits that bother me very much.	I do not have a great fear of snakes.
Once in a while I feel hate toward members of my family whom I usually love.	I believe there is a Devil and a Hell in afterlife.
I have often felt that strangers were looking at me critically.	I believe in a life hereafter.
I have been disappointed in love.	My table manners are not quite as good at home as when I am out in company.
I enjoy reading love stories.	I have never had any breaking out on my skin which worried me.
At times my thoughts have raced ahead faster than I could speak them.	It does not bother me that I am not better looking.
	I am entirely self-confident.
	I daydream very little.
	I should like to belong to several clubs or lodges.
My hands have not become clumsy or awkward.	I like to go to parties or other affairs where there is lots of loud fun.
	I like to be with a crowd of people who play jokes on one another.
	I enjoy a race or game better when I bet on it.
	Most people make friends because friends are likely to be useful to them.
It takes a lot of argument to convince most people of the truth.	Most people are honest chiefly through fear of being caught.
	When someone does me a wrong I feel I should pay him back, if only for the principle of the thing.
	I feel that it is certainly best to keep my mouth shut when I am in trouble.
	When I take a new job I like to be tipped off on who should be gotten next to.
	In walking I am very careful to step over sidewalk cracks.
	I sometimes tease animals.
If I were an artist I would like to draw flowers.	I think I would like the kind of work a forest ranger does.
I would like to be a florist.	I very much like hunting.

I like collecting flowers or growing house plants.
I think I would like the work of a librarian.
I like poetry.
If I were a reporter I would very much like reporting news of the theater.
I like to cook.
I like dramatics.
I would like to be a journalist.
I would like to be a singer.
I would like to be a nurse.
I used to like drop the handkerchief.
I used to keep a diary.
I liked "Alice in Wonderland" by Lewis Carroll.
I would like to be a soldier.
I think I would like the work of a building contractor.
I like science.
If I were a reporter I would like very much to report sporting news.
I like mechanics magazines.
There never was a time in my life when I liked to play with dolls.

A variable measured by the Minnesota Inventory, which also is primarily interesting from the viewpoint of basic motivation, is *psychopathic deviation.* It will be stressed in the next chapter that the psychopathic personality in particular is considered to be a syndrome largely expressive of uncontrolled infantile ego assertion.

It is seen then that by tapping the patient's interests and preferences, tests such as the Bernreuter, the Terman-Miles, the Allport, and the Minnesota Inventory may be of considerable clinical utility. However, because in such tests the patient's conscious or intentional behavior is involved, the true picture of underlying psychodynamics is usually if not always partly distorted. Not only can the patient deliberately disguise motives by selection of items, but even without intention he reflects in such conscious choices of alternatives the very patterns of disguise and repression that it is necessary to penetrate.

Methods That Utilize the Projection of the Personality in Fantasy

In his earliest work Freud (41) stressed the psychological significance of dreams as a means whereby the individual acts out conflicts that are unrecognized by himself but basic to his personality. To Freud the obvious content of the dream was such as to disguise from the patient its significance; he believed that the dream's content could be interpreted symbolically as revealing the nature of the conflicts themselves. Since Freud's early work, much attention has

been given to the analysis of fantasy materials as they reveal dynamic patterns of motivation and solutions to conflicts.

For purposes of clinical analysis, principal types of fantasy material are *dreams*, *play*, *art*, and *stories*. With children particularly, Levy (90), Erikson (39), and others have found free play and play with selected toys to be extremely useful. The child's behavior is interpreted as an acting out of personalized patterns of love and aggression and solutions to conflicts that are basic to his personality.

A most fruitful technique is the Thematic Apperception Test, developed by Murray (98, 101, 102) and Sanford (123). This test consists in presenting the patient with a number of pictures, mostly of humans in situations that require some explanation as to setting and outcome. Potentially dramatic, the pictures offer to most patients dynamic possibilities. Asked simply to tell a story that explains the setting and the outcome (the forces at work and the solution to the problem), the patient's themes of action may be violent or passive, disastrous or comforting to the hero of the story. Since the patient usually identifies the central character with himself and other characters with parents or friends, his own conflicts seem to be projected into his stories. In persistent themes of action chosen by the patient, the clinician finds reinforcement for his opinion of the dynamic situation as a counterpart of the conflicts and hoped-for solutions in the patient's own life.

The Patient's Autobiography as Dynamic Retrospection

Murray found also that the patient's autobiography was extremely useful in clinical understanding, not so much of motivational factors, perhaps, as of early environmental influences and of incidents in the patient's life that were of psychogenetic significance.

An extremely brief procedure that is clinically useful in this respect is to ask the patient to tell his earliest memories. One technique[1] asks three such questions:

Write a brief answer to each of the following:

1. The earliest thing I can remember is.....
2. The most pleasant thing that ever happened to me was.....
3. The most unpleasant memory I have is.....

Obviously the patient's selection or avoidance of certain areas in describing his life and his emphasis of ideals and interests reveal

[1] Suggested by Erik Wright and Floyd Due.

much both directly and by inference about the basic emotional and motivational factors in his development.

The Rorschach as a Measure of Basic Motivational Factors

Just as fantasy represents a projection of the patient's personal dynamics, so his perceptions are determined also by his personal life experience. It is natural that his perceptive interpretations of the Rorschach ink blots are productions that reveal these experiential aspects of the personality. As compared with the thematic apperception pictures, the Rorschach ink blots are to the patient relatively meaningless. The forms are intentionally diffuse and nonpictorial. In his effort to relate these strange figures to things seen or experienced and with only the question, "What might this be?" the patient must rely totally on himself. His solution to the problem is highly personal, and it is clear that we find in his perceptions and their difference from what others see many clues to his individuality.

Motivational factors are revealed in the Rorschach experiment principally in *movement*, in *content*, and in the analysis of *sequence* of responses. Spontaneity or activeness of the inner life is expressed in the patient's use of movement. Klopfer (81) has stressed the importance particularly of animal movement in revealing basic impulses and their importance in the personality structure. Children use animal movement freely, while adults tend to use human movement. Klopfer feels that in adolescents and adults a predominance of animal movement over human movement reveals the strength of infantile urges and a lack of development of adult control of these urges. The use of restrained or passive movement, or of inanimate movement, like explosions or uncontrollable forces, is considered indicative of self-restraint and hence of anxiety of the individual about impulses within himself.

In *content*, or the nature of forms seen, and particularly in the nature of action when it is used, motivational aspects are often revealed. Action that is aggressive or disastrous, or tentative or pending, seems to reflect the importance of similar forces within the individual. For many individuals the blots are sexually suggestive; the patient's responses may vary from a healthy expression of sexual forms to repression because they are suggestive. Often symbolic interpretations of the sexual significance of forms seen can be used in a manner similar to that used in interpretation of dream material.

By analysis of the sequence of responses is meant the interpretation of the patient's responses in terms of their departure from the usual response to the changing nature of the blots. Certain of the blots are more likely than others, for example, to evoke sexual responses. Hence, when the patient on one of these blots gives a response of poorer quality, more hesitantly, or in a markedly different manner than that used on other blots—even though his response is entirely conventional—we can endow it at least tentatively with some significance as an indicator of sexual responsiveness.

CHAPTER IX

APPRAISAL OF MOTIVATION—II. INADEQUACIES OF MOTIVATION

Uncontrolled Motivation: Infantilism

The normal, happy child is proverbially regarded as carefree, uninhibited, freely expressive, impulsive. Although we are at times irritated by exaggeration in his behavior, we nevertheless expect and tolerate a certain amount of mischief. Indeed, it is our very willingness to put up with his normal selfishness that makes it possible for him to avoid frustration, with the result that he is rarely frustrated and made anxious for long. His life is devoted entirely to the pleasures of the moment, uncomplicated by social obligations, and the child is narcissistic; he is egocentric and gets away with it. At least in our own culture he is naturally dependent on his mother, for it is she who, directly or indirectly, satisfies all his needs.

As he grows, we expect the child more and more to become considerate of others and to become civilized. This we call the process of maturity. But some children never "grow up." Even as adults they are egocentric. Little concerned about the consequences of their impulsive behavior, which often leads to disaster, they are infantile. They may be criminal. Their frequent use of alcohol and sexual aberration often complicates the picture. Cleckley (29) suggests as the criteria of this *psychopathic personality* the following:

1. Positive superficial impression; no intellectual deterioration.
2. Free from demonstrable irrationality, psychosis, nervousness, neurosis.
3. Unreliable, no sense of social responsibility.
4. Disregard for truth.
5. Never sincerely accepts blame, though perfunctorily is full of self-blame.
6. No sense of shame.
7. Commits fraud, even without a goal.
8. Lacks judgment.
9. Does not learn from experience.

10. Egocentric—an invariable characteristic.
11. Poverty of affect.
12. Lacks insight.
13. Unresponsive to treatment of himself by others.
14. Alcoholic indulgence frequent.
15. Bizarre behavior while drinking.
16. No suicidal drive.
17. Peculiar sex life—weak drive, though often obscene.
18. Adverse heredity.
19. Tendency shown any time—not necessarily in early life.
20. Lacking in purpose.
21. Psychopath driven to failure, self-destruction.

Several of these characteristics are recognized immediately as not at all typical of the normal child, so that the psychopathic personality is not simply a protraction of childhood bliss. The psychopathic adult is comparable to the child whose motivation has been energized a hundredfold. In the psychopathic personality freedom of expression is paramount. Possessed of the adult's sexual drive, the psychopath sees no reason for restraining it. Aggressive, he takes what he wants. In the process of enjoying himself—having a good time—sex and alcohol are incidentals. In need of an environment that—like the child's environment—will not frown too sharply on his behavior, the typical psychopath seeks out the brothel and tavern, not because he is sexually distorted and alcoholic, but because he is there more sure of tolerance and acceptance.

It is interesting to examine the questions of the Minnesota Inventory that contribute toward a score for *psychopathic deviate.* There are 50 items which contribute one point each; of these 50, 32 also contribute toward scores for one or more of the following variables: *hysteria, hypochondriasis, psychasthenia, paranoia, depression, hypomania,* and/or *schizophrenia.* The 18 items that contribute only toward the score for *psychopathic deviate* are as follows:

Answered "True"

I have used alcohol excessively.
My family does not like the work I have chosen (or the work I intend to choose for my life work).
There is very little love and companionship in my family as compared to other homes.
My parents have often objected to the kind of people I went around with.
My parents and family find more fault with me than they should.
I have been disappointed in love.[1]

[1] *Item* also contributes toward masculinity-femininity.

In school I was sometimes sent to the principal for cutting up
I have not lived the right kind of life.
These days I find it hard not to give up hope of amounting to something.
My way of doing things is apt to be misunderstood by others.

Answered "False"

I have been quite independent and free from family rule.
I have very few quarrels with members of my family.
My relatives are nearly all in sympathy with me.
I liked school.
I like to talk about sex.[1]
I do not mind being made fun of.
I have very few fears compared to my friends.
I am easily downed in an argument.

The following case is presented in some detail, in order to show how the clinical material, as it develops, serves to suggest, controvert, or reinforce the impression of the personality pattern.

A twenty-six-year-old white male, a naval recruit of two weeks, whom we may call George, was referred to the neuropsychiatric screening unit by his company commander because of persistent complaints of backache and headache. History obtained entirely from George himself revealed that he was one of twin boys. One older sibling, a sister, died of diphtheria while the twins were infants. By the time they reached the age of ten, three younger brothers and two sisters had been born to the family. George stated that "all the family are high-strung like I am, I guess." He claimed, however, to have gotten along well with both parents. His father, twenty years older than his mother, was a building and plumbing contractor, and apparently made a fair living; at least the family owned a car. Since her first child was born when she was sixteen, it is obvious that George's mother married very young.

A nailbiter even as an adult when worried, George bit his fingernails persistently in childhood. He was enuretic until late adolescence. At seven or eight he first noticed sharp pains in his abdomen, and from that time intermittently. Details of his school career were vague. Apparently his progress through the grades was uninterrupted, but he was frequently truant; at sixteen in the face of threatened punishment by the principal he quit the ninth grade. He claimed to have worked after school, in drugstores, in a radio repair shop, and so forth; he admitted the fact that at fourteen he was arrested and paroled in connection with stealing some tennis balls from a private club and arrested and fined at fifteen for stealing gasoline. After leaving school, he worked at various jobs and finally drifted into his principal occupation, that of painter. Although he

[1] *Item* also contributes toward masculinity-femininity.

occasionally ran away from home, he remained more or less with his family until he was about nineteen, after which he began traveling in earnest.

That his traveling was not always luxurious was apparent in the finding that he was arrested frequently for "riding the rails," for vagrancy, and for investigation. At seventeen he was arrested for burglary, involving a radio, and for fighting with a policeman. This occurred on Halloween, and he claimed the whole incident to have been unfair because the officer was in plain clothes.

After his initial heterosexual attempts at about fourteen, George indulged in frequent love affairs, usually with "pickups." He used a condom only if the girl "looked funny." (He claimed never to have suffered venereal infection.) In the course of his travels he married, at twenty, a girl whom he had known three months. According to his story they got along well until a year after marriage a child was born. From that point on, George frequently left home (in the Southwest). Advised by a painter in Chicago that by traveling about the country he would "learn more about painting that way," he obtained jobs through friends who wrote him about their own jobs. "I'd pack up and go." Returning home, he found his wife eager to go out and enjoy herself; she did not agree with him that, since he was home for a rest, her station was at his side. During the year following the birth of their child, George and his wife quarreled frequently. He claimed later that on one occasion she threatened to shoot him. At another point, while he was in Massachusetts, she wrote telling him that another man had offered to take her and their child to California. Whatever the facts, George rushed home; they agreed to divorce. She obtained the decree on the grounds of cruelty and desertion, but was awarded no alimony. George was given custody of the child. Sexual factors seemed to be entirely secondary in the discord between husband and wife; George said that although he could enjoy sexual relations with his wife three or four times a week, he never resented it when she was disinclined. It was clear that George blamed marital discord entirely on his wife, and even took a certain self-righteous pleasure in the fact that he, not she, was awarded custody of the child.

Although during the years from his eighteenth through his twentieth year George was usually away from home, a series of events occurred that were of probable significance in their effect on him. When he was nineteen, his youngest brother, aged seven, was drowned. The following year his next younger brother was killed at sixteen in a train accident (details undisclosed). The following year George's father died of tuberculosis at fifty-nine, although, according to George's statement, he "began going down-hill after my little brother was drowned." During these years also, George's twin brother finally left to embark on a career of his own, after which the brothers saw little of one another. With the father dead, and his twin away entirely from the home, George was left after his

divorce in the position of major-domo, at least enough to complain about it. His twin and the remaining twenty-two-year-old brother being 4F, they and the twenty-four-year-old sister "won't help support my mother; they are too selfish. They promise to help but never do." George did not seem bitter about this, but he did feel that it was a burden upon him.

Largely incidental in George's history was the use of alcohol. He began drinking socially at about eighteen, and at twenty-six had learned to appreciate drinking as a solitary as well as social stimulant. Its effect was not at all to stimulate him sexually. Rather, he tended to want to be with others, with the gang. During the six-months period when his marital affair was at a critical stage he drank a quart a day, but at other times he was fairly moderate. Sometimes he drank on the job.

Occasionally fired from jobs, he more often quit because he "didn't like the foreman." In connection with others becoming overbearing, he stated, "I won't tolerate that in anybody." During his recruit training George had one fight, with a petty officer. Although not himself one of the group, he had stood up for some shipmates who, he claimed, were unjustly assigned extra duty; when his opinion had been questioned he had gotten into a scrap.

Let us now examine George's performance on a few tests, and compare the findings with the history obtained.

First, the Wechsler-Bellevue.[1] On this scale, his proficiency on the verbal tests placed him at the level of I.Q. 112. He did particularly well on Comprehension and on Digits (I.Q. about 130). Performance with the Block Designs test placed him at the level of I.Q. 108. Thus, we see that he is of good average mental capacity—a fact that corroborates his school history as he reported it.

These are the stories he told for 12 of the thematic apperception pictures:[2]

Picture[3]

1. 4 This fellow's mind seems 10,000 miles away from what she's talking about or maybe she's worried about what she's talking about, it seems from expression on their faces. More than likely it's

[1] Wechsler (143) discusses quite fully the pattern of performance with his tests that he considers most typical of the psychopathic personality; he stresses in particular the tendency for the psychopath to give a better performance on the nonverbal than on the verbal test.

[2] Kutash (85) discusses the performance of psychopathic defective criminals on the Thematic Apperception Test.

[3] The full series of the Thematic Apperception Test consists of 30 pictures. Of these, several (without letter designations) are suggested for use with either sex and with adolescents as well as adults. Of the remainder, those suggested for males are designated as B (boys) or M (adult males), while those for females are designated as G (girls) or F (adult females).

family trouble, and he doesn't want to talk about it. (Outcome?) He looks like an intelligent fellow and more than likely it will come out all right. He'll probably agree to whatever is on her mind. She looks sensible enough.

2. 13 MF This fellow here looks like he's worried about his wife. She's more than likely pregnant. By the looks of the room it's maybe out in the country and he's waiting for the doctor. He looks tense and worried. He's just like most all fathers, I guess. Probably a thousand things running through his mind. Probably his first child—there's none other in the picture. (Outcome?) She looks normal and healthy enough and everything will be all right even if the doctor didn't show up. The fellow looks like the type who's easily excited. If the doctor doesn't show up he'll get coolheaded enough to have an idea of what he should do.

3. 20 This seems to be a Wave or Red Cross worker, or probably a civilian watcher. I can't tell whether these are lights or a raid on the town. She's probably a long way from home and has a lot on her mind. She looks pretty lonely. She more than likely knows these things have to be done, and after it's all over will be tickled to death to get back where she was.

4. 18 BM This fellow seems to be—someone's forcing him to have his picture made. He 's evidently a criminal of some kind or could be a saboteur of some kind, or spy in this time. He looks intelligent enough; he has weak features—more than likely a hijacker and hijacked someone and didn't get away fast enough and got caught. Probably he wouldn't have been suspected, and for that reason he didn't want his picture took. (Outcome?) A fellow like that makes enough to have been doing that for awhile or to be worth some money, and he will more than likely go to the pen.

5. 17 BM This fellow is an athlete of some kind around a swimming pool or gym. He seems to be moving across something and has a lot of expression in his face, wondering if he'll make it or not. He has a determined look and will probably make it. Looks like he's at some meet. A fellow like him will probably come out first.

6. 7 BM Looks like a father and son. The son seems to have done something wrong or he hasn't lived up to what his father expected. His father has given him some advice but the son resents it. Looks like he's old enough that he should understand and take advice his father wants to give him. In two or three years he will probably realize his father is right and he'll realize to take the advice. He looks intelligent enough and will probably come

out all right. Looks like college guy who went there for the fun of it instead of what he could get.

7. 3 BM This looks like a boy that—either he's shot somebody or evidently has a brother or father or someone close to him in the service. If it's someone in the service, he's more than likely praying and wondering why he did it. He's so young that whether he shot someone or is wishing his father or brother was home he'll probably come out all right.

8. 14 This lady's husband or son is probably a flier and she's just heard some planes and wonders if he's in the planes. Maybe he's overseas and she's wondering what he's doing and maybe she's saying a prayer for him and wondering when he'll get back. From her profile she looks like she's cool enough and her son's smart enough to take care of himself. She hates to think of anything happening to him, but if, but if it does he can do things to compensate for his injuries. She'll probably go to bed and be all right.

9. 9 BM This looks like a bunch of fellows who have had a pretty busy day, or maybe it's just after lunch hour. They're probably colored cotton pickers. Don't look like they got a care, a worry in the world. Probably when their rest is over they'll be up singing and picking more cotton till the end of the day. They're probably from some Alabama or Louisiana plantation, or probably never off the plantation. They're content to pick cotton or anything the boss wants them to do. When they're old they'll be children and grandchildren to take their place doing just what they're doing now.

10. 5 This lady is evidently looking for something—probably one of her children. She has been all through the house looking and has some word for them. They ran out on her. Her expression doesn't seem too sincere, so she's probably has some word for them. They ran out on her. Her expression doesn't seem too sincere, so she's probably used to it. She won't find her children and will probably go ahead and do the work herself. She looks like the type of woman who doesn't worry too much even if her children don't help her. She's happy just having the children. She'll probably go on everyday just doing this. Even if the children are this way she'll go through life being just as good to them as she could be.

11. 6 BM This fellow seems to have made some kind of decision that his mother doesn't approve of. He thinks he's right and she doesn't want to disagree with him, yet she knows it isn't right. It's more than likely some business matter. Or perhaps he's

studied something in school, and he's about old enough to think of marriage and this will interfere with his business. His mother is thinking of his future and wants him to wait. With her advice and his intelligence they'll probably come out all right.

12. 3 GF This lady looks heartbroken for some reason or other. Maybe she's lost her husband or her child. This has about got me stumped. She seems to be taking it pretty tough and regardless of what it is she'll—isn't it all right if I pass this? I can't think of anything.

What do these stories reveal about George's motivation? It is apparent that personal interaction is of great significance to him, and of greatest importance are the sentimental values to be attached to social relationships. George frequently emphasizes intelligence in his characters; the central figures in his stories frequently are required to use their wits. The hero in almost all of the stories either by avoiding trouble or by achieving the goal finally makes the grade because he is smart. It is interesting that the achievement of success in almost all instances involves incidentally some suffering in others. It is essential that the hero make an impression on others. Situations with women always favor the man, and situations involving only men usually reveal the hero to be misunderstood.

George gave the following Rorschach[1] responses:

I. (6″) Looks like to me it could be a butterfly or some kind of insect. I'd say a butterfly or some kind of insect.

II. (14″) Is this the right side up for that? Oh, it looks like a rabbit (because humped and jumping).

III. (10″) It looks like it might represent a lamb or one of those English dogs they have . . . (either side usual human figure, no texture).

IV. (20″) I don't know . . . you got me on this one (laughs). That looks like it could be a snail from there out (pointing to usual head D)—I don't know what the rest of this is. . . .

V. (R at 20″) I don't know . . . I'm stumped on this one . . . I don't see anything that looks like it . . . (Enq: It represents some common butterfly.)

[1] Lindner (92) discusses the diagnosis of psychopathic personality by means of the Rorschach.

VI. (R at 30″) I wouldn't say on this one, either . . . (Enq: I've never seen anything look like it.)

VII. (18″) Looks like a bunch of (seems to be floating off) clouds to me . . . I'd say clouds. . . .

VIII. (10″) This looks like a cougar or mountain lion. (The way they're set—seems like they're gettin' ready to jump.)

IX. (10″) Just some blotted colors. . . .

X. (10″) Just some more blotted colors. Looks like an imaginary sea horse there (center green). (Points to upper green detail lateral.) What did they call that bull with one horn way back in history? Similar to that . . . (Seems to be charging.)

The impression given by this Rorschach record, with its paucity of response, animal movement, direct use of color, and the rejections of two figures is that of an infantile, poorly integrated personality—impulsive, aggressive, and lacking in inner resources. Environmental stimulation has the effect of arousing strong primitive impulses, but as if for some reason their expression were unacceptable or regrettable, they seem to eventuate in anxiety. Left to his own devices, George possesses little stability; as revealed particularly in his response to (VII), he is emotionally sterile, repressed, and anxious. In social situations George is egocentric and egoistic, and moved to impulsive expression; this sometimes leads to trouble, however, and he tends sometimes to retreat. In this tendency to withdraw he vacillates—sometimes cautious, sometimes foolhardy. Despite intellectual capacity that is at least average, George does not understand himself; dominated so fully by childish forces within himself and a childish tendency to overreact socially, he fails to produce.

Following are the scores made by George for the several variables of the Minnesota scale; they are presented as standard or T scores. A score of 50 is average, while scores as deviant as 70 or greater are suspect of psychopathology. The variables on which his scores were so variant as to be suspect are capitalized.

Number of "Cannot say"	50
Lie score	50
Validity score	58
HYPOCHONDRIASIS	88

DEPRESSION	77
HYSTERIA	78
PSYCHOPATHIC DEVIATE	75
Interest (femininity)	39
Paranoia	56
Psychasthenia	64
Schizophrenia	60
Hypomania	59

We shall discuss in later chapters the syndromic nature of many of these variables of the Minnesota Inventory; it is important here to note that of the four variables on which George showed suggestive deviation, one was the variable, *psychopathic deviate.*

How closely does George fit the picture of the psychopathic personality as developed by Cleckley? With recourse to none of the test data gathered in the case, and on the basis only of interview, two clinicians[1] rated George on a group of traits: they agreed that he was attractive, well oriented, unreliable, unconcerned about the future, inconsistent in his goals, impulsive, consumed alcohol excessively and often in solitude, and that sexually he was promiscuous, casual, and motivated by self-love rather than object love. These characteristics are all consistent with Cleckley's psychopathic personality. The clinicians were, however, as well agreed regarding certain other traits, somewhat out of line with Cleckley's description. They felt that George was fairly truthful, responsible, and somewhat tense (neurotic). Their impression of emotional tension is borne out, of course, by the evidence revealed in the test performances. George revealed considerable anxiety on the Rorschach, and many of his answers to the Minnesota questions show that he is absorbed with somatic complaints and hence scored high on *hypochondriasis* and *hysteria.* It is important that George first came to the attention of the neuropsychiatric unit because of his complaint of back pains and headache and that he had suffered abdominal pain frequently since childhood. Physical examination revealed no physical basis for these complaints: they had to be considered neurotic. Like alcohol and incidental love affairs, these complaints offered to George another means of gaining attention, *i.e.*, reassurance to his ego. It is apparent that George was more neurotic than the classic psychopathic personality, but it is also apparent that his maladjustment was an expression most of an infantile, self-centered, impulsive moti-

[1] Dr. L. A. Pennington and Dr. R. G. Kuhlen.

vation, a way of living characteristic essentially of the psychopathic tendency.

Maladjustments Associated Primarily with Inadequate Development of Sexual Motivation. Homosexuality

Just as maladjustment characterized by the psychopathic personality may be considered an adult expression of narcissistic behavior, so in various distortions of adult sexual motivation we find patterns of behavior that characterize later childhood stages of normal psychosexual development. The psychopathic personality may be considered an arrest, as it were, at the level of development during which the individual's motivation is entirely toward ego satisfaction. Similarly, the psychogenesis of homosexual patterns of behavior seems to be in the nature of an arrest in development at the level during which normal childhood motivation is toward the same rather than the opposite sex.

The Universal Nature of Homosexuality. Difficult because of the strict social taboos that surround the whole subject of sexual behavior, it is nevertheless important to understand sexual maladjustments in the light of normal sexual development. The problem of homosexuality, rather than being a problem of undesirable and unacceptable behavior, is one of public opinion and social prejudice operating to accentuate maladjustment rather than to prevent it or help it.

It is extremely doubtful that any individual is purely heterosexual in behavior, just as it is highly improbable that we ever encounter a purely homosexual individual. Essentially, there are two criteria by which we judge behavior to be homosexual rather than heterosexual: behavior is to be considered homosexual that reveals (*a*) motivation toward the same rather than the opposite sex, (*b*) qualities in the personality that are characteristic of the opposite rather than the same sex.

In normal social usage we find many expressions that meet either one or the other of these two criteria and, though unrecognized as such, are therefore homosexual. Behavior motivated toward the same rather than the opposite sex is revealed in many societies, such as fraternities and sororities, or in the organization of athletic teams. Among women more so than men, physical embraces and other demonstrations of affection reveal similar motivation. Certainly the members of a social group composed exclusively of members of

the same sex are not homosexuals, but their social relationship is a reflection of normal affinity for the same sex and hence reveals normal homosexual motivation.

When we consider the second criterion above—the extent to which members of one sex exhibit in their behavior characteristics of the opposite sex, we see in every personality evidences of homosexuality. Studies of the masculinity or femininity of interests show consistently and forcefully that in all men there are feminine traits and in all women attributes that are masculine. The coexistence of masculine and feminine traits in all individuals is universal, a fact that indicates that everyone to some extent is homosexual as well as heterosexual.

Stated as it is in terms of *tendencies* in behavior, this broad definition of homosexuality is in strong contrast to popular restriction of the term "homosexuality" to overt sexual approaches or acts between members of the same sex. The approaches or acts to which society reacts so strongly are usually if not always extreme or uninhibited expressions of homosexual motivation. Although extreme in that they are socially unacceptable, these approaches or acts are essentially episodic and incidental, just as heterosexual intercourse is an incidental expression of heterosexual love.

The difference between the popular concept of homosexuality and the broad concept (here used because it is necessary for an adequate understanding of the problem) is a difference not only in the degree of overtness of behavior. In the light of differences between the sexes, there is a second and more subtle definition of homosexuality, one that involves the two criteria above, *viz.*, the direction of motivation and the masculinity or femininity of behavior displayed.

In our earlier discussion of motivation and development it was suggested that behavior that is aggressive and dominant is traditionally considered to be masculine; behavior that is passive is considered to be feminine. For the successful culmination of normal sexual intercourse each of these opposite roles is essential. Of even greater significance, however, is the fact that in their counterpart these roles are preserved traditionally in correct social behavior between the sexes. The man initiates the date. He ushers the woman into the car, buys the tickets, tips the waiter, etc. It is he, not she, who is the "wolf." It is, indeed, as a final expression of this active-passive relationship between sexual partners that satisfactory love and marriage eventuate.

Returning to the problem of homosexuality, it should be emphasized that the nature of the social role assumed by the individual is of primary importance. Regardless of the sex of the individual, social aggression is to be considered masculine, and social passivity is to be considered feminine. Thus it is that in the passive male and in the aggressive female homosexual tendencies are most clearly revealed.

In normal adult behavior it is probable that there is a more tacit acceptance of homosexuality in women than in men. Women are expected often to be openly affectionate, while men are expected to avoid mutual embraces. Again, at the stage of social development in "a man's world" when women have become increasingly independent and self-sustaining, the qualities of competitiveness and aggressiveness, essentially masculine, are in women entirely acceptable as qualities of desirable motivation. The greater freedom permitted women in adopting characteristics of the opposite sex is shown by styles of dress that are frequently tailored in masculine fashion, while for men to adopt even minor female adornments immediately occasions the raised eyebrow.

In understanding the differences between the sexes in the degree to which homosexuality is revealed in their behavior, it is important to consider that man's heterosexuality is evidenced by his self-assertion. Since it is customary for the man to propose marriage, his hesitancy is considered by some to be an avoidance of heterosexuality.[1] Spinsterhood of the woman, expected passively to await the proposal of marriage, cannot be inferred to be similarly an avoidance of heterosexuality.

Because of society's greater tolerance of homosexuality in women, it is probable that there are among women in contrast to men fewer of those maladjustments that are referable primarily to homosexual conflicts. Another way of stating the case is that the greater censure for men presents the greater conflict and the greater chance for extreme maladjustment.

Maladjustments Associated Primarily with Homosexuality. Conflicts regarding homosexual tendencies are basic not only to forms of maladjustment that are expressed in unusual sexual behavior, but to many patterns of neurotic and psychotic deviation, in which there

[1] This assumption is highly questionable, for the reason that (a) many bachelors are promiscuously heterosexual, and (b) that marriage and children are frequently considered to be compensatory attempts to deny basic homosexuality.

is nothing of manifest significance sexually. In the psychogenesis of maladjustments in which homosexual motivation seems to be important but in which there is no overt expression of homosexual activity the term *latent homosexuality* is often used. In the discussion of inadequate forms of control in Chap. XII certain forms of maladjustment will be discussed in which latent homosexuality is often of considerable significance. In the remainder of the present discussion of homosexuality, we shall limit ourselves to those maladjustments that are characterized by activities on the part of the patient that are overtly homosexual.

Because of the frequency with which the overt homosexual demonstrates physical as well as psychological characteristics of the opposite sex, there is considerable speculation as to the essentially physiological nature of homosexuality. Physical characteristics, such as hair distribution, breast development, and the development of the adult bodily contour, which emerge at puberty are of greatest significance in this regard. Of particular interest is the endocrinology of the individual, and there have been many studies made to determine the psychological correlates of endocrine factors. That the absence of the gonads is reflected in behavior that is less sexual has been known since the days of eunuch slaves. Under certain forms of endocrine therapy there have also been positive demonstrations of alterations in sexual behavior.

Such suggestive evidence of the importance of physical factors in sexuality is strengthened by the fact that overt homosexuals sometimes exhibit very markedly the physical characteristics—not only structurally, but in movements and in walk—of the opposite sex. However, there are so many more cases of overt homosexuality in which physical and physiological characteristics are typical of the *appropriate* sex that a theory of physical explanation for more than a few cases is definitely ruled out. Often the most frankly homosexual activities are initiated by individuals whose appearance and mannerisms are normal in every way.

In evaluating the factors underlying the maladjustment of the patient whose behavior is characterized by overt homosexual acts, the clinician must assure himself of several possibilities.

First, despite the evidence, is it not possible that the patient's essential motivation is heterosexual rather than homosexual, and that homosexual activities were the result of an inability—for whatever reason—to achieve heterosexual satisfaction? In ruling out

the possibility of essential heterosexuality it is important to learn whether the patient's satisfaction is really greater in his experience of relations with his own rather than with the opposite sex. In many cases of overt homosexual behavior far greater satisfaction is derived from heterosexual than from homosexual activity. The frequency of homosexual activities where celibacy is enforced, as in boarding schools or among men at war, in persons whose heterosexuality is obvious under other conditions indicates very strongly that homosexual acts are no certain indicator of basic homosexual tendency.

It is important for the clinician to understand also the nature of those sexual activities which for the patient are most pleasurable. In the discussion of the development of sexuality, mention was made of the emerging specificity of certain areas of the body as erogenous zones. Just as there is a difference between males and females in the assumption of the aggressive or the passive role, so there is a difference between the sexes in the significance of the erogenous zones. For the *normal* heterosexual woman pleasure is aroused by stimulation of erogenous areas, including the lips, the breasts, and the buttocks, as well as the area of the vagina. In normal heterosexual intercourse, greatest pleasure is derived from stimulation of the genital area, and it is this stimulation by the penis of the male that results in successful completion of the sexual act. For the true male homosexual it is often the case that stimulation in the genital area is ineffectual. In this sense he is feminine. Satisfaction may be aroused only through stimulation by the partner's penis of erogenous areas such as the lips or buttocks. Lacking the vagina he may center his motivation on achievement of orgasm in the partner, and so utilize the mouth or rectum as substitute.

Pleasure for the man in *normal* sexual intercourse is derived not only from sensation in the genital area, but from the very assertion of aggression itself, paramount in which is the urge to stimulate the genital area of the woman specifically by the penis. The true homosexual woman in assuming the aggressive role toward the partner may derive certain pleasure from erogenous stimulation, but she feels an urge particularly to stimulate aggressively the genital area of the partner as if with a penis-like projection. It is frequently the case, therefore, that she uses not only the hand but even the tongue in this attempt. There are cases reported in which mechanical devices have been used to take the place of the penis.

Through an evaluation, then, of the nature of overt homosexual activities particularly regarding the social role and the areas of stimulation that for the patient arouse the greatest pleasure, it is possible to arrive at a determination of the essential masculinity or femininity of the personality. If the male who is overtly homosexual is passive and if he derives little satisfaction from genital stimulation, he may be considered a person of true homosexual motivation. The woman who is overtly homosexual and who derives greatest satisfaction from giving rather than receiving sexual stimulation may be considered to be of true homosexual motivation.

Homosexuality and Adjustment. It has been suggested above that the problem of homosexuality is primarily one of public opinion and social prejudice. The demonstration of overt homosexuality is a sign of maladjustment only because society will not tolerate such behavior. Many true homosexuals live useful and constructive lives, but they do this under great difficulties. By means of sheer repression of homosexual impulses it is possible for some to disguise their tendencies socially. Since sheer repression is at best an uncertain and unsatisfactory form of control, such individuals are frequently maladjusted and are most apt to develop anxiety and psychopathological forms of expression.[1]

A second alternative for the true homosexual to disguise basic motivation and an alternative that permits nevertheless some achievement of satisfaction is by means of *sublimation.* Sublimation is in essence a means whereby basic motivation is directed toward useful and socially acceptable channels, in such a way as to permit indirect satisfaction of these basic impulses. For men who are true homosexuals and who cannot reconcile themselves to overt homosexual expression, sublimated expressions are often found in activities that are essentially fenimine, such as in art, in nursing, in hairdressing, in dancing, or in interior decorating. In the same way the truly homosexual woman may sublimate her basic impulses in activities that are essentially masculine. It has been suggested that in the present day of emancipation of woman direct competition with men is highly acceptable, so that a business career is always possible. In athletic sports, in physical training and education true homosexual women often find satisfactory outlets as substitutes for overt expression of their sexuality.

[1] A recent and good description of the homosexual's use of alcohol as a solution to his conflict is provided in the story *The Lost Weekend,* by Charles Jackson (71).

The true homosexual has, of course, the third alternative, that of the open recognition and satisfaction of basic impulses. For the heterosexual individual, marriage is the socially acceptable means whereby sexual impulses may be expressed. In similar manner, homosexuals often live intimately with members of the same sex. But because this is particularly repulsive to society, such arrangement is precarious at best. Hence, homosexuals as a minority group, in protest to the world so to speak, often associate together in large groups. Within these groups there are special mores, special forms of recognition, and often even a special language that is strange to the outside world. Many homosexuals live contentedly under these conditions, and some feel even a defensive superiority intellectually and socially toward the majority (heterosexual) group on the outside. But it is among the members of such a homosexual microcosm that the clinician often finds the most serious maladjustments. No arrangement is sufficiently clandestine to screen off the rest of society. Individual members of the group in the simple task of making a livelihood still must compete with the heterosexual majority. Society looks upon such persons as "queers," and, looking from without, endows such social relationships with aspects of immorality. From the viewpoint of society, overt homosexuals are considered, together with pimps and prostitutes, as members of the demimonde. Thus to consider the homosexual a creature whose whole life is a matter of perverted sexual activity is, of course, grossly unfair. But such prejudice is nevertheless the reality which the overt homosexual must face. It is not surprising then that many overt homosexuals encountered clinically are severely maladjusted, not because they find their impulses unacceptable, but because society will not tolerate their expression.

The following case study is taken from the collection of cases of sexual deviation presented by Henry (63).[1] Other excellent case studies of sexual maladjustments and the results of tests of interests are presented in the book of Terman and Miles (136).

Gladys is a slender, boyish girl of twenty-three with clear-cut features. She has dark, wavy hair, clear blue eyes, a large mouth, thick lips, protruding upper teeth, and a prominent nose. She has very little of the rounded feminine contour. Her shoulders are distinctly angular and broader than her hips, her breasts appear adolescent and she has rather heavy wrists and ankles.

[1] Reprinted by permission of Paul B. Hoeber, Inc., Harper & Brothers.

Although cooperative and frank in regard to her personal experiences she was cautious about leaving any record which might disclose her identity. She was friendly in her attitude but showed her insecurity by smiling effusively when embarrassed. During the first interview she tensely smoked one cigarette after another and at its end she announced relief that an ordeal was over.

In subsequent interviews she was more relaxed and there was a suggestion of an attempt to make a favorable impression upon the writer in the hope that he might assist her in gaining admission to a medical school. Gladys is eager for experience and is working energetically at a clerical job in the hope that she may be able to go on with a college and medical education.

Her insecurity was expressed in a fear that she might acquire the tuberculosis with which some of her family have been afflicted and that this illness might prevent her from studying medicine.

Family background:

There isn't very much I can tell you about my father's family. Grandfather dominated the affairs of the family and everyone was afraid of him. Grandmother was a very good housewife who lived only for her family. Both of them were of Irish descent.

The oldest of their seven children was an aggressive domineering aunt who was rather prudish and just vegetated. She announced to a couple of friends of the family who wanted to marry her that she wasn't going to get married and she didn't.

Next was an uncle who died of tuberculosis at the age of thirty. His only daughter was reared with mid-Victorian ideals.

His younger sister was married three times. Her first two husbands died. The third was a weakling whom she dominated completely. She made the lives of all three of them miserable. They had to hang up their clothes before they went to bed and they were not permitted to smoke in the house.

All of the remaining four in this generation were equally aggressive and domineering. One was a priest, the second a police sergeant, and the youngest a fire chief. The police sergeant had about a dozen children and the fire chief was quite promiscuous until his marriage at thirty-seven.

My father died of heart trouble when he was thirty-five. All his life he knew he had a defective heart but was very courageous. He took good care of his four children and made a marvelous husband. I remember only two quarrels that he had with Mother. In one of these I was awakened in the middle of the night. He was in the habit of taking liquor for his heart pains. This time he had taken too much and Mother was trying to get him to go to bed. The other quarrel was when a cousin of mine had attacked me and my father wanted to make a court case out of it.

Mother's father was born in Venezuela of a Spanish mother and a German father. This grandfather of mine was a linguist, educated in Europe, but he was not fitted for any special work so he became a liquor salesman. He was much older than grandmother and died when Mother was young.

Grandmother was a German peasant, a good cook, and a very good housewife. She was very aggressive and domineering and fond of giving tongue lashings. She preferred her sons to the extent of refusing to have her picture taken with either of her daughters. Her moral code was very strict and she was decided in her opinions on family affairs. She didn't object to my mother changing her religion but she did object to Mother bringing her children up in the Roman Catholic faith.

The oldest of Mother's generation was my Aunt Blanche. She made a mess of her marriage because she really didn't know what was required of a wife. Her husband was a very heavy drinker and there was much quarreling over his drinking. After five years of wrangling they separated. He wouldn't give her a divorce so she went ahead and lived with another man. Five years ago I had a very nice quarrel with her. I used to wear a shirt and tie and boy's shoes to the office and she objected although she was a business woman and wore tailored clothes herself. For two years afterwards I had a terrific feeling against her. She wanted to dominate the affairs of others but found it was useless to try.

Last winter in the flu epidemic she would say that I was going the way one of my uncles did because I was studying so hard. She had it that I would be down with tuberculosis in a week. She's a Calamity Jane but I was terribly scared for a while.

One of my uncles was a very studious physician. Occasionally Mother says I resemble him in looks and disposition. Everyone made an idol of him. He was doing research work in bacteriology but died at twenty-five while still an assistant in a laboratory. Although he had been married only a year his wife was unfaithful to him. She remarried a few months after his death.

The other uncle was very good looking and very pleasant. He used to bring candy to me. He went out with a different girl every night and was forever writing to his sweethearts that he had no intention of marrying any of them. Twenty years ago he went West and nothing has been heard of him since.

Mother had a slight frame and was rather dumpy. She weighed only eighty-two when she was married. Before her marriage she was employed in business and interrupted this to start training as a nurse. A nervous breakdown prevented her from completing the course. She was always rather quiet and her family always came first. After father died she worked very hard. While she was in business she liked the company of

a much older woman but she was interested in men to the extent of considering them as husbands. Several years ago she married again and since then she has changed a good deal. She now lives only for her second husband.

I'm the oldest of the children and consequently my two sisters and my brother have not yet had much experience with the world. The older sister has kidney trouble and refuses all medical attention. She has a very poor sense of values, she quarrels with everyone about everything and is very unstable in her opinions. She smokes only for exhibitionistic purposes and uses make-up to excess although she objects to others using it. She's afraid to marry because of her poor health, afraid she will be like Aunt Blanche and yet she is not satisfied unmarried. Right now she is afraid that I may take a boy friend away from her. She's afraid I will be better looking than she is when I get my teeth straightened. She's a very selfish person. I think she's vile. She's inclined to complain about everything under the sun and would be a hypochondriac if we let her.

The other sister is still in high school. She's very serious and much disgusted by petting. She is tall and heavy and is careless about her personal appearance.

My brother is also a high school student. He has always been slight in build and is about my size. Until a year or two ago I used to wear his shirts and I always had a supply of his ties on hand. He hasn't matured emotionally at all. He still feels that girls are just pests.

Personal history:

They tell me that my birth was premature—at a little more than six months. Mother was ill during the entire pregnancy, had to stay in bed and lived on milk. I was breast fed for six months and from a bottle for three days and then I took milk from a cup. Until I was seven years old there was much trouble getting me to eat. I had to be forced to eat. Mother was most concerned and used to sit with me until I ate. All one summer when I was three I lived entirely on ice cream. I liked the plate it was served in. Occasionally they could get me to eat by taking me out to dinner. The little girl next door could get me to drink my milk. She was two years older and I was very fond of her. I still eat only from sheer necessity. I don't know why I didn't eat. My analytical mind has failed me in that. I will eat a pound of fruit at a time but I don't like to sit down to a meal.

Perhaps as a consequence of my peculiar diet my teeth were slow in erupting and I didn't talk until I was two. Aunt Blanche swore I was deaf and dumb because I grunted when I wanted anything. Then she concluded that I was just dumb. When I finally did begin to talk I used full sentences.

I don't know whether the fact that I was easily frightened at night and walked in my sleep had anything to do with the experience I had

with a cousin when I was a little over three. He was thirteen and had probably made other attempts. This time we were in a room together and I had no clothing on. I have no memory of pleasure or pain but Mother got me to tell the whole story and concluded that the sex act had been completed. This resulted in a quarrel in the family.

During childhood I played Indians and other adventurous games with the children in the neighborhood. I preferred boys as playmates because their courage more nearly matched my own than did that of girls. I did have a very nice doll but I never played with it and I was mortified when they gave me another just before I was twelve. I threw it away.

On the whole I was a rather solitary child. This was probably caused by my desire to be a boy. Mother and Grandmother always preferred boys and were very much disappointed when the first two children were girls. Mother told me this. I liked my mother, my father and my grandmother but I never showed affection to any member of the family. I have always resented being kissed by them.

Most of my education was obtained in a parochial school. I never took the religious training seriously. The majority of my classmates were average boys who overrode all discipline. I was much younger than the others in the class.

By the time I was thirteen I had become attached to a girl three years older. We walked to school and ate lunch together. She had very large breasts. Two years after I met her I tried kissing her but stopped because she said she would tell my mother. I suppose it was a sexual attachment.

Another older girl became attached to me at this time. She was very well developed and I was sexually aroused by her breasts. My only recollection of this attachment was my desire to kiss her breasts.

Boys didn't interest me. I played hide-and-seek with mixed groups but I always managed to hide with a girl. One night a boy picked a very secluded spot and tried to kiss me. I didn't like it. It was very pleasant to talk to him but I didn't like to kiss him.

I went to a girls' high school where I didn't know anyone. It took a long time to make friends but I sensed the close intimacy existing between some of the girls. Much of my energy was spent in swimming and I played ball with the other girls. In the third year I became seriously attracted to a teacher who had just been married. She was slightly taller and nicely built but not good looking. Her body was well developed. I like well developed breasts, not just large ones. It makes me feel tense to talk about this. She seemed to prefer men but she was very pleasant to me. She invited me and another girl to her apartment and I saw a lot of her in class. I joined a special class to be able to see more of her. She would wait for me and look for me around the school. We had ice cream together when we were working late. I worked hard for her but she gave me higher marks than I deserved. I felt sexually aroused in

her presence. My heart would beat fast and I would blush and feel very nervous. I just wanted to hold her and kiss her but I had no opportunity.

Although I got out of school at twelve-thirty I didn't get home until five. Mother objected to this and made me stay up until midnight to help with the sewing. My clothing didn't interest me at this time and not until I was eighteen. I just wore the clothes that Mother provided and there was never anything frilly.

When I was seventeen I started working after hours in a five and ten cent store and at the same time carried a heavy program at school. I felt exhausted and I quarreled about everything and with everyone, especially at home. I don't recall that I had any special feeling toward my older sister as a young child, except over the fact that she ate everything, and I had no interest in food. Later on she teased me about my teeth and my glasses. My very young sister didn't seem worth quarreling with but the last entry in my diary was that of a quarrel with my brother. Our quarrels usually ended with a fist fight and I wished I were a boy so I could meet him on his own ground. All of this seems funny now as I look back on it.

Through a girl in the next block I met several other girls who interested me. One girl read what I like and enjoyed concerts. Our interests were intellectual. There was nothing sexual but I really liked her. I also went with a nicely built and decidedly feminine girl who was engaged to be married. Although I felt sexually attracted to her I denied it. Another girl felt very much hurt because I went with this girl.

At this time I had many arguments about homosexuality with the hygiene teacher. She had told us that the cause was purely environmental and I said it wasn't. All the time I was dying to see her alone. I wanted to kiss her at least.

As far as my interest in girls was concerned Mother was tolerant and understanding. She always knew exactly where I was but she never questioned my preference for girl companions and neither forbade my spending nights with them nor having them as fortnight guests in our home. She had given me adequate adolescent instruction but did not urge marriage or even preoccupation with men. Her tolerance is not surprising in view of her own very close intimacy with a slightly older woman which may have had some sexual outlet.

My father died when I was nine and for some time afterward I slept with Mother. She was always cold and I would have to warm up the bed for her. I used to see red and fight like a wild cat if the kids scolded her and for a while during early adolescence I had a desire to be close to her. I think the doctor finally advised against my sleeping with her.

After I graduated from high school I worked in an office and the subway furnished an excellent opportunity to be close to one of my girl friends.

We would use the rush hours to stand face to face and press our bodies together. At other times I would grab her and hold her and kiss her on the mouth. Although I despised shopping I went with her just to be near her. I made it a point to be seen with her as much as possible. I think it was a form of exhibitionism. Half of the time I would have my arm around her waist. We were oblivious of everything except each other. Kissing this girl used to arouse me decidedly and the sexual desire was by this time located in the genital region.

I remember one very unpleasant afternoon riding with my girl friend in the back of a car and with a fellow alongside of us. He wanted to sit between us. The girl and I kissed each other for three hours. This fellow was engaged to her sister. When we got back her father was home and she and I went upstairs and kissed each other some more.

Some time later at a family party they announced the engagement of this girl instead of that of her sister. The sister had a nervous breakdown and my girl friend said she had been forced into it by her family. Everything went to pieces. I had no one I could tell although my friends knew that I was mad about her. They were stunned when they heard of her engagement.

After that my health was very bad. I had severe indigestion and lost weight. In spite of the fact that I was under doctor's care, went to bed at seven or eight, and ate enormous meals I kept losing weight. I kept on swimming three times a week but felt exhausted all the time.

This went on for over a year and then I joined the Girl Scouts because I was leading too secluded a life. Soon I fell madly in love with one of the scouts. It was just a physical attraction. She was engaged in research work and had very little time. I discovered that she was having an affair with another girl and as far as I was concerned it was just a case of hands off. While in camp I could easily have had an affair with another girl but I refused to sleep with her.

When I was nineteen my cousin's brother-in-law made sexual advances to me but I refused him. I objected to necking with him because I didn't want to start family arguments. For a while I tolerated him because his mother had picked me out for his wife.

Men don't mean a thing to me. I enjoy talking to them and sometimes I'm extremely jealous of them because they have better opportunities for education but they mean nothing to me sexually. I used to go to dances twice a week but it was just a habit. I wouldn't tolerate kissing or close embraces. After I had been dancing with one man for a short time he held me tightly and I fainted. I thought it was due to the heat. Then another man danced with me and held me tightly and I fainted again. After that I stopped going to dances.

Two years ago I began to sleep with a girl. I took the initiative in kissing her all over. I began genital kissing instinctively but I still

prefer the breasts. This affair lasted about a year and when she left me I was absolutely desperate.

During this time I was also much interested in an art teacher. I was doing wood carving and for several months I went every night and spent every bit of my energy on the carving. This teacher is a homosexual but she was not my lover. She is charming personally and also charming in the way she teaches art. She encouraged me to go on with my education.

About a year ago I decided that I had too much energy and that I should cut down on my eating. I soon found that about all I could do was to move and now I don't have energy enough to do the things I want to do.

I can't understand the change. I have cut down my social life to almost nothing. People think it's a very lonesome life I lead but it really isn't. I'm still trying to get into a premedical course and after I start that I can't have any social life or at least I don't intend to.

I have even become a Puritan. I'm scandalized when my sister indulges in petting. I give my reasons and she just says it's being done. A few years ago I was doing things and she had the same attitude towards me. I thought I was sincere then. The fact that I have changed indicates that I was not sincere.

While I was in high school something happened to me. I was all wrought up and simply frightened to meet anyone. I had a terrible feeling of insecurity until I was twenty. Perhaps it was just plain self-consciousness. I've gotten away from that adolescent crowd in the sense that they don't attract me and perhaps I'm not attractive to them. For a while after I gave up everything I had considerable sexual desire but I haven't much now. Now I get along very well with boys. I don't pet but still I manage to hold my own. We usually go to a show.

My nearest friend is the girl I am working with. She is sixteen years older and more masculine than I am. She's about the finest person I know. I think a lot of her. She has traveled a lot and her judgment is perfect. I'm willing to take advice and criticism from her. She has kept me in school and has supplied the extra push necessary to make me stick at it. I've decided to concentrate on my studies rather than spend a lot of time with girls.

I can't imagine myself married but I've changed a good deal in the past year or two and I may change again. My stepfather can't imagine a girl not getting married. I don't see how I could marry but still I'm not willing to say that I won't. My notion of an ideal man is one with broad shoulders and narrow hips. That'a a nice build for anyone. I hate women with hips as broad as their shoulders. I wouldn't like to have a child of my own and I don't think I could hold a home together. A woman

who remains single can be more selfish. I've gotten so selfish that it's not funny. (Pages 1009–1017.)

Physically, Gladys was of the boyish, athletic type, small, with straight arms, relatively long legs. Distribution of subcutaneous fat was fairly juvenile, her breasts were somewhat flat, with small nipples. The skull was considered to be female, while the pelvis tended toward the masculine. Hair distribution was generally feminine.

On the Terman-Miles interest test of masculinity-femininity[1] she made scores that, together with their percentile equivalents for both men and women at the college sophomore level, were as follows:

Test	Raw score	Male percentile	Female percentile
I. Word Association	−23	Less than 5	5
II. Ink Blot Association	+1	70	95
III. Information	+1	18	85
IV. Emotional and Ethical Response	+42	82	95
V. Interests	+35	50	95+
VI. Personalities and Opinions	+10	90	95+
VII. Introvertive Response	−1	55	80
Total	+65	40	99+

No analysis of these test results is presented with the case study, but it seems significant that there is such wide variability or scatter among these subtests of the measure of masculinity. Gladys' total score of +65 places her in the 99th percentile for college sophomore women, indicating a strong tendency toward masculinity of interests as measured by this test. It is noteworthy that her score, markedly masculine on six of the tests, is on the seventh—the Word Association test—just as extremely feminine. Essentially a projective technique, the Word Association test has more in common with the projective Ink Blot Association test than with the remaining five tests, all of which involve interests and preferences at a relatively conscious level.

In a recent article by Karwoski, Gramlich, and Arnott (75) comparison was made of the nature of associations in response to words and those in response to visually presented materials (drawings and

[1] Henry presents only the raw scores. The percentile scores were obtained from Terman-Miles (136).

objects). Associations to words were chiefly static—names of associated responses. Reaction time to words was shorter than reaction time to drawings. Responses to objects and drawings tended to be of a dynamic or operational nature. The inference was that the greater reaction time for response to the visually presented materials might involve a step intermediate between stimulus and response.

The study cited above might suggest that our subject, Gladys, fairly on the road to an intellectual integration of her basic impulses and the professional opportunities not inconsistent with them, had achieved a verbal rationalization that was a pattern of femininity not only convincing to others but granting her a certain real security. It served as a reduction of anxiety and a competence when tested verbally to project femalewise. But in the cultural pattern less familiar—the visual in contrast to the verbal—the patient's projection was less sophisticated or less feminine, perhaps less guarded, and more consistent with the direction of her attitudes and interests. We may see here an example of the partly educated, intelligent, insightful individual whose motivation toward personal integration is excellent; through the careful elaboration of verbal but static femininity (as measured by the Word Association test) she has achieved a defense that permits her latent masculinity (revealed in her Ink Blot performance) even to express itself openly in the preferences, interest, and attitudes measured by the remaining subtests.

Henry presents the following interpretive summary of the clinical observations of Gladys:

> Gladys seems to have had abundant opportunity to get acquainted with aggressive, domineering people. Everyone was afraid of the paternal grandfather and at least six of his seven children sought to impose their wishes upon others. In the mother's family the grandmother and Aunt Blanche took the lead in running the affairs of others. In comparison to these two women the uncles were lacking in masculine traits.
>
> The parents seem to have been fairly well adjusted to each other. Gladys had a high regard for her father as a courageous man who, in spite of serious heart trouble, took good care of his family. The mother also is credited with being loyal to her family even though she may have been sexually intimate with an older woman.
>
> Indications of the mother's instability are manifest in a nervous breakdown which prevented her from completing a course of training as a nurse and in her invalidism while carrying Gladys. This invalidism probably was an expression of the mother's resistance to pregnancy and it is in

keeping with her inability to get Gladys established in regular dietary habits.

As far as her own hygiene was concerned Gladys had a poor start in life. Her birth was premature and she was slow in developing. She was so pampered and spoiled with regard to her diet that she still eats only from sheer necessity and she seldom eats a regular meal.

Gladys also showed her instability through being frightened at night and by sleepwalking. The sexual assault upon her at the age of three seems to have been more disturbing to the family than to Gladys herself.

Difference of opinion in the family with respect to Gladys did not simplify matters. The mother apparently was unduly solicitous, catered to Gladys' whims and used to sit with her until she ate. The aggressive Aunt Blanche, who was unable to manage her own affairs, at first took the position that Gladys was deaf and dumb and later that she was just dumb. As a result Gladys developed a feeling of animosity for this aunt which was accentuated in their subsequent conflicts.

On the whole Gladys was a solitary child. Her mother and her grandmother preferred boys and were disappointed that Gladys was not a boy. Gladys herself wished she were a boy and she always behaved as though she were one. She reacted to this attitude of the family by showing no affection for any of them.

At puberty Gladys discovered that she was inclined to passionate attachment to girls and that she was aroused by girls who had large breasts. Gladys wished to kiss and caress these breasts. This attraction may have been a residual manifestation of the inadequate nursing attention she received in infancy.

In the girls' high school which Gladys attended she had opportunity to give expression to her preference for girls. She felt sexually aroused in the presence of her girl friends. She not only sensed the close intimacy existing between some of the girls but she took an active interest in discussing homosexuality.

For some years after the father died Gladys took his place in the family. She slept with the mother, defended her, and had a desire to be close to her. The feeling was mutual as the mother never questioned Gladys' preference for girls and did not urge preoccupation with men. The nature of the attachment between Gladys and her mother was sufficiently obvious for a doctor to advise against their sleeping together.

With this general background it was a short step to overt homosexual expression. Gladys availed herself of the opportunities to press her body against that of her girl friend and thus more definitely localize her passions in the genital region.

Gladys became so active in her pursuit that her girl friend's family took drastic action to break up the alliance by forcing the girl into marriage. Gladys then reacted with digestive disturbances with which she and her

mother had been so familiar. Although Gladys tried to compensate for the loss of her lover by eating enormous meals she kept on losing weight and felt exhausted.

The nature of her disorder was further established by her recovery on falling madly in love with a girl scout. It was a physical attraction which had no overt expression but it helped Gladys to give up her secluded life for one that was much more hygienic.

Finally she took the initiative in kissing the girl and she resumed her caressing of breasts. When the girl left her Gladys was absolutely desperate. This affair, for the time being at least, crystallized her homosexual desires and made it evident that men meant nothing to her sexually.

In the past few years Gladys has tended to revert to a previous inactive state in which she restricts her diet unwisely and remains by herself. This is done under the guise of concentrating on her studies rather than spending time with girls.

Gladys now feels that she gets along very well with boys. She probably has become more tolerant of them but she is scandalized by her sister's petting; she cannot imagine herself as a wife or a mother. Her closest friend is a masculine girl sixteen years older. This woman is the finest person that Gladys knows. She serves as a mother and a father, supplies the funds, and gives the extra push necessary to make Gladys stick at her studies. (Pages 1018–1020.)

Inadequacies of Heterosexual Behavior

In successful adjustment it is essential that the individual find satisfaction for the basic needs of ego recognition and love, for in the frustration or inadequate satisfaction of these normal motives we find the key to much unhappiness. In earlier chapters we have tried to show how emotional security for the child is derived from the love of the parents. In the process of normal development from infancy to maturity emotional security stems less and less from the parents and increasingly from social relationships developed outside the family circle, until ultimately the normal heterosexual love relationship is achieved. Conventionally this relationship is marriage.

To suggest that this single gradual evolution of heterosexual love is fundamental to all successful adjustment may seem to place too strong emphasis on sexual factors. The objection may be raised that to consider the love between man and wife simply as sexual adjustment serves to focus attention on sexual intercourse and to neglect many other and more important aspects of a happy marriage. This would indeed be a valid criticism if we restricted our use of the concept of sexual adjustment to mean only the capacity for

heterosexual intercourse. We might have chosen instead the term "happy marriage," for in our civilization the successful marriage is the prototype of adult love. But because marriage is primarily a social expression of mutual love—a social institution—and only secondarily (certainly not necessarily) a personal expression, it is psychologically more meaningful to use the term "sexual adjustment."

In its broader sense, sexual adjustment in adulthood is a delicately balanced and ever-changing relationship between partners of whom is required a merger, as it were, of impulses and interests in the cause of mutual need and satisfaction. Sexual adjustment implies, not only satisfaction of the basic needs for ego recognition and love, but also the *giving* of love and hence, in a sense, a partial surrender of the ego. Sexual adjustment is never absolute and infallible. It is relative. It is a dynamic flux of emotional interaction between partners in all aspects of their daily living. Rarely if ever is sexual adjustment perfect, because it demands continual adaptation and sacrifice.

In the setting of sexual adjustment, its most intense and beautiful expression is in sexual intercourse, but this expression because of its very naturalness is essentially incidental. In the happy marriage, intercourse is a natural physical and psychological experience which is appreciated mutually by man and wife and which serves as a mutual reassurance of love. It is when this natural expression and reassurance is frustrated that unhappiness is likely to appear, as revealed particularly in other aspects of the marriage. Under conditions of frustration the sexual act loses its incidental and natural quality and becomes of inordinate importance. Where the need for love and reassurance cannot be entirely satisfied, sexual intercourse becomes a source of annoyance, and the husband or wife in thus failing to find and give love and reassurance finds rejection and frustration.

The psychological synonymity between sexual adjustment and marital happiness is well expressed in the early stages of marriage, a period during which essential psychological relationships between husband and wife are developed. In the achievement of the delicate balance necessary for marital satisfaction the husband and wife experience frequent frustrations of ego and love impulses. This is particularly true of their attempts at sexual expression. During these early years when needs are great and satisfactions are vital, emotional discord often appears, as revealed by the incidence of divorce. In the course of the happy marriage, as husband and wife

gradually adjust themselves, the enjoyment of sexual intercourse loses its inordinate significance as a problem of individual satisfaction and becomes a natural expression of mutual love.

Heterosexual Frustration. Although often quite unrealized or unaccepted by the patient, sexual frustration in many cases of maladjustment is a prominent feature. An attitude in the patient of avoidance or disinterest regarding sexual matters often suggests, not that sexual factors are unimportant, but rather that they are of primary significance. It is important therefore that the clinician appreciate the nature of sexual frustration and the manner in which inadequacies of heterosexual behavior develop.

Since full sexual expression is a mutual function, it is obvious that one source of frustration is the *partner's resistance or avoidance.* Because of his initiatory and aggressive role, it is usually the man who experiences this type of frustration. It is in the nature of woman's passive role that sexual arousal is a slower and more subtle process than in the case of the man. Stimulation of the erogenous zones of the woman is usually a prelude to her necessary relaxation. In the excitation of the man stimulation of erogenous zones is secondary, for partial arousal normally precedes and induces the sexual approach. Since this is true, mild frustration by the partner's initial passivity is experienced to some extent by the man in the prelude to normal intercourse and acts as a further excitant. It is when resistance by the partner is continued after full sexual arousal that frustration becomes of significance in its expression in maladjustment. Repeated experience of such direct frustration of sexual expression is unpleasant; failing to give reassurance and satisfaction to either partner, it is therefore likely soon to be terminated.

Although direct frustration by the partner is sometimes important in maladjustment, most frustrations occur because of the individual's own incapacity for full sexual expression and satisfaction. In a few cases *the physical condition of the individual* is of primary concern, as in cases of disease or structural defect that make intercourse impossible. These conditions are specific and readily diagnosed by a competent physician. In the great preponderance of cases of inability to achieve normal sexual expression the underlying factors are entirely psychological. The sexual act is characterized by physical adaptation of each partner to the other, and without proper motivation and emotional response this adaptation is impossible.

One important physiological factor in sexual adjustment is age.

In the course of maturity and the gradual onset of senescence, or old age, the individual undergoes a natural diminution of sexual activity known as *involution.* In women this phase is characterized by the cessation of the menstrual cycle and is therefore known as the *menopause.* This occurs usually during the forties. Occurring later and somewhat more gradually in men, involutional changes are characterized by the gradual loss of *potency*, or the capacity to maintain erection of the penis. In neither sex is the loss of sexual function necessarily accompanied by a corresponding decrease in sexual motivation and the need for sexual expression, a factor that in many normal cases engenders frustration and anxiety revealed in personality changes. Involutional conflicts are sometimes so severe that they eventuate in maladjustment and even psychosis. The involutional patient is usually, of course, quite unaware of sexual frustration; his depression eventuated, in his own opinion, because of the onset of old age.

The individual who is incapable of achieving sexual expression is sometimes considered to be lacking in sexual desire. For women who show this physical incapacity the term "frigidity" is used, a counterpart of the term "impotence" in men. Frigidity is characterized by an inability to relax the vaginal opening sufficiently to permit the introduction of the penis. Characteristic also of unsatisfactory sexual expression is the woman's failure to achieve orgasm. A very large percentage of women though not frigid never experience this fullest expression of sexual feeling.

To consider the impotent or frigid individual lacking in sexual desire is essentially erroneous. Such a person toward another partner or under other conditions may well demonstrate considerable sexual motivation and success. It is for this reason that psychological factors that affect the individual's capacity for sexual expression require careful consideration.

One factor just suggested was *inadequate love for the partner.* Often this factor is prominent even when the external signs of conviviality and connubial bliss are present and when love is expressed conventionally. The fond husband whose eyes wander frequently to the legs of the girl coming down the street or the wife who feels a need to have younger men about the house often suffer simply because the partner has lost glamour and is no longer exciting. Essentially, the partner is no longer adequately loved. Often one's unwillingness to reconcile oneself to the loss of love and the desperate

attempt to overcome impotence or frigidity—to achieve sexual expression despite incapacity—is a source of bitter frustration. The clinician often encounters the woman who is eager to satisfy her husband, though the experience of coitus is otherwise painful.

Incomplete psychosexual development often contributes to heterosexual maladjustment through lack of interest in the opposite sex. In cases of ambivalent sexuality, where the polarity of development as masculine or feminine is not clear, we sometimes find unusual expressions of heterosexuality. We find, for example, that the woman assumes the aggressive role toward the passive man.[1] An unusual expression of homosexuality is sometimes found in the individual who attempts to deny such tendencies within himself by asserting his heterosexuality promiscuously and even with fertility.

Of the significant psychological factors which underlie frustration of heterosexuality, by far the most frequent are those that betray the *restraint of one's heterosexuality.* In such cases the direction of motivation in that it is clearly heterosexual is entirely satisfactory, but factors such as early psychological shocks or anxiety or fear serve to restrain or prevent sexual expression. *Fear of the consequences* of sexual intercourse is often an important inhibitor of expression, a restraint that even the use of contraceptives does not entirely dispel. This fear psychologically is more important in women than in men, because of the complex of values that for her are represented by pregnancy as a social phenomenon and childbirth as a dreaded experience. The use of contraceptives is an important factor, not entirely because the element of fear is presumably reduced by the exercise of caution, but because the very exercise of caution itself betrays a restraint of expression.

Particularly before marriage, *fear of venereal disease* is an inhibitor of full sexual expression—a conscious restraint possibly desirable for hygienic reasons and one of rare significance after marriage. When this fear is prominent in the infrequent marital situation, it is usually in a context of distrust of the partner's fidelity, and many other factors are introduced.

Although partly recognized fears are of frequent importance in the frustration of sexual expression, they are in normal circumstances easily reduced by means of mutual understanding and adaptation. They are rarely accountable singly for the sexual frustration so

[1] In an excellent discussion of woman's sexuality, Helene Deutsch (35) has interpreted the biography of George Sand in the light of her aggressive femininity.

extreme as to be characterized by impotence and frigidity. Of considerably greater importance in this respect are fears not fully realized by the individual, fears which are experienced as generalized uncertainty or *anxiety* and which stem from early psychosexual development. Anxiety and repression are revealed often in an attitude on the part of the patient of prudishness or of disgust with things sexual. They are considered animal. Often revealed is the feeling that sexual freedom even in the sanctity of marriage is an immoral indulgence. Usually such attitudes are outgrowths of guilt feelings arising from conflicts about masturbation during childhood, a guilt that later is associated with all things sexual.

Before marriage, frankly sexual activities are usually fragmentary and incidental and often experienced surreptitiously in an atmosphere of fear of detection of the consequences. They are often traumatic and unpleasant and frequently are followed by regret. The early years of marriage, therefore, often not only present the first opportunity to develop satisfactory sexual expression, but they require the individual to overcome earlier prejudices and the effects of unfortunate episodes. It is during these years that the most tender love of the sexual partner is required so that further frustrations will not occur. During the early marital phase of adjustment sexual frustration arises largely from the difficulty with which each partner must sacrifice individuality and become identified in mutual expression. Since his is the initiatory role, the man must prevent shock or pain to the partner that might result from impetuous assertion of aggression. It is essential that full sexual arousal in the woman be first achieved before attempt is made to introduce the penis. This requires of him patience under conditions of increasing urgency of expression and often results in premature ejaculation, followed by detumescence of the penis and hence a frustration to the woman. The timing of expression so that the climax in orgasm is experienced simultaneously is essential to ideal intercourse and developed only under conditions of deep understanding.

Very often satisfactory sexual expression is achieved by embrace far less intense than the sexual act. Indeed, it is essential that the sexual act be regarded simply as an occasionally experienced intensity of mutual embrace rather than as a specialized activity apart from other marital activities. In her passive role it is sometimes difficult for the woman to understand fully the significance of the man's sexual arousal and approach as an expression of love and need for

love rather than of need simply for ejaculation. Not fully aroused, she may thus resent the selfishness of the partner's approach and in her resistance deny herself and him the mutual reassurance that might be expressed in quiet embrace as well as full sexual expression.

Distortions of Heterosexual Behavior. The clinician frequently encounters maladjustments in which an *inordinate degree of heterosexual motivation* is apparent. These characterize individuals who, in the promiscuity with which they seek sexual expression, appear never to be satisfied. For such persons the repeated success of conquest—the reassurance of virility or of sex appeal—seems to serve as a reinforcement of the ego. Don Juan or his female counterpart—the nymphomaniac—seeks erotic satisfaction, not in the experience of full heterosexual expression, but in erotic expression that is essentially selfish and therefore akin to masturbation. Though overtly heterosexual, motivation in such cases is only secondarily toward love, for like that of the psychopathic personality the dominant theme appears to be a need for ego recognition.

The double standard under which our present society is largely organized permits freedom of sexual expression in men considerably more than in women. The man finds outlets of expression more readily than does the woman.

For this reason there is in men less maladjustment referable to such exaggerated sexual drive. This form of maladjustment occurs most frequently among married men—in the situation of the wife's incompatibility or where for moral reasons or fear of detection infidelity is to the man an unpleasant alternative.

No matter how enjoyable, promiscuity in women either before or after marriage is always a danger. Of the many psychological factors underlying prostitution, it is probable that early environmental influences, economic need, and mental deficiency are of frequent importance, but in at least a few cases the inordinate need for sexual expression is undoubtedly of primary significance. An adequate understanding of nymphomania requires consideration of aspects of sexual motivation other than the urge simply for self-satisfaction.

Aggression and Passivity. We have seen in the discussion of psychosexual development that masculinity is identified with aggression and femininity with passivity and that in courtship and in social customs these roles are necessary and typical of adjustment. The concept of Beauty and the Beast is deeply rooted in human behavior.

This relationship between aggression and sexual advance, while fundamental to normal adjustment, is such that exaggerations sometimes occur and are expressed in pathological behavior. The extreme of aggression is characterized by the infliction of pain, and behavior that appears principally directed toward this end is said to be *sadistic*. Extreme passive behavior, directed primarily toward the endurance of pain, is said to be *masochistic*. In normal sexual expression the conscious desire of the man is hardly to inflict pain on his beloved, nor is it her desire consciously to be hurt. It is true, however, that in the normal sex act the woman is highly stimulated by aggression of increasing intensity and even violence.

Because of their relationship to sexual motivation sadistic and masochistic impulses sometimes appear as predominant erotic expressions. Partly because of the paradoxical psychology of an urge to enjoy pain, masochistic tendencies are less often encountered than sadistic. However, in rare instances one learns of an individual who is aroused sexually solely by severe beating or other treatment that could be considered only painful or degrading to the ego. In the nymphomaniac, masochistic urges are probably of significance. There have been instances of women for whom erotic satisfaction could be achieved only from intercourse with animals. Masochism in men is found, of course, in the behavior of the passive homosexual, who sometimes suffers considerable pain in relations with the male partner.

It is in the demonstration of sadistic more than in masochistic behavior that we find frequent expression of pathological adjustment. Rape, of course, is the prototype of sadistic attack. The frequent combination of sexual assault and murder—often of children—is evidence of the criminal extremity to which the aggressive and erotic impulses are sometimes merged. Acts of cruelty quite out of the context of sexual attack, such as cruelty toward prisoners or toward children or toward animals, often indicate that the sadist derives satisfaction purely from cruelty. The sadist's behavior, like that of the psychopath, is motivated toward self-satisfaction, but in sadistic behavior the motivation is, through the infliction of pain, toward achievement of erotic satisfaction rather than simply ego recognition.

It is obvious that in normal behavior sensory factors are of considerable significance in facilitating or inhibiting sexual expression. Physical beauty, particularly of the woman, is a stimulant to courtship, the appreciation of which by all women is shown in their

attention to clothes and the choice of perfumery. It is the essence of femininity to attract attention and—even if sometimes by suggestive disguise—to accentuate the essential femininity of the person. Behavior that is directed primarily toward the attraction of attention to oneself is called *exhibitionistic.* It is, of course, narcissistic. Characteristic of normal feminine behavior, exhibitionism in some individuals seems sometimes to be the dominant means of erotic satisfaction. Undoubtedly it is basic in the personality of many theatrical and motion-picture stars. In its extreme, associated directly with exposure of the sexual anatomy, it is, of course, a pathological expression.

The masculine counterpart of exhibitionism—the urge to observe—is expressed in the man's normal appreciation of the female figure, his relish of "pin-up" pictures, and his preponderant attendance at burlesque shows and night clubs where the female figure is the dominant artistic motif. When erotic satisfaction is sought and experienced chiefly through sexual observation we speak of *voyeurism.* In some cases this urge fulfills or dominates the individual's sexual motivation. It is basic, for example, in pornography and in the art one occasionally sees in public toilets. Its pathological expression is found in the Peeping Tom.

In cases of pathological exhibitionism and voyeurism we often find an association with masturbation. This suggests that in psychogenesis the fantasy of the individual at the level of infantile masturbation is of importance. Although motivation in such cases appears usually to be heterosexual, the individual's erotic satisfaction is derived, not from full heterosexual expression, but from a complex of appropriate sensory stimulation and self-induced orgasm. An interesting expression of this merging of sensory factors with masturbation is revealed in the case of *fetishism.* The fetishist achieves erotic satisfaction through the manipulation of a particular article—usually an article of clothing—which has sensual significance and which serves to stimulate fantasy like that of masturbation.

Also related to voyeurism and fetishism in that sensory factors are of dominant significance is the pathological expression found in the behavior of the *pyromaniac,* the individual who feels an uncontrollable urge to set fire. The objective of the pyromaniac is to observe the fire. In our everyday references to love as a "burning passion" or "burning desire" and in our slang reference to a particular girl as a "hot number," the symbolic significance of fire as

representing the sex act is revealed normally. In psychopathological fantasy this symbolism is often very apparent. Hence, it is not strange that often the pyromaniac finds erotic satisfaction in masturbation simultaneously with observation of fire.

Somewhat akin to voyeurism is the urge to feel and explore manually the body of the partner, an urge that in normal sexual behavior is a natural expression of the man's aggression and desire to stimulate the partner. In the man who is an inveterate "fanny patter" this impulse approaches the pathological. Probably this tactile urge is often of importance in fetishism.

These unusual expressions of sexual motivation are rarely of such dominance that they are central to maladjustment, but when they are evident in pathological degree they suggest deep-seated conflicts originating in childhood and an immature control of motivation. Because such expressions are essentially infantile distortions they are, as such, psychopathic.

CHAPTER X

APPRAISAL OF CONTROL—I. GENERAL CONSIDERATIONS AND CLINICAL METHODS OF STUDY

We have suggested in earlier chapters that the individual's personal civilization—*i.e.*, his acquisition of socially acceptable means of expressing basic impulses—is essentially the development of *control.* From moment to moment in everyday life the degree of control is variable because the demands of the environment upon the individual are ever-changing. In normal behavior we see fluctuations in emotionality. For the normal person to show fear in the presence of immediate danger is natural and understandable, and we expect him under provocation to express joy and grief and anger. The essence of emotional stability is that the fluctuations of control be *appropriate* and *in proportion to the environmental circumstances that seem to induce them.* It is when the usual expression of emotions are inappropriate or exaggerated or less than we might expect that we become suspicious of something wrong in the personality. The man who laughs at the wrong time seems to us somewhat queer. The woman who cries too easily or too often or who "goes to pieces" seems to lack a necessary emotional integration and stability. Indeed, the common expression "losing control of himself" puts in plain words the concept of losing a desirable integration of emotion, whether the outburst be aggressive or one of fear or of remorse. In losing control the individual seems for the moment to react as a child reacts, to express himself impulsively and without restraint.

The effect on the personality of the moderate use of alcohol gives in converse a good picture of the operation of control. In a general sense, the effect of alcohol on most individuals is to permit the gradual release of inhibitions of basic impulses. There are wide differences between drinkers in their behavior while intoxicated. Some become aggressive, others sentimental and tearful, others erotic. Depending on the person's characteristic pattern of basic

motivation, these various expressions of disinhibition have this in common: they are less civilized, less cultured, more impulsive and childlike. The drunk is more satisfied with himself or at least more tolerant of his weaknesses than he is when sober. His ego receives a boost. The effect of alcohol is hence to permit the normal individual to behave more like the traditional psychopath, the uninhibited child.

It is the purpose of this chapter to discuss both the nature of this control that is acquired in the course of emotional development and certain of the procedures for its clinical study. In the three chapters that follow we shall discuss the maladjustments that are expressed as inadequacies principally in the development or maintenance of control.

Overcontrol or Constriction

Just as the behavior of the psychopath may be considered a deficiency in the acquisition and operation of control, so we find in some individuals such inordinate control that emotional expression is severely inhibited. The person appears pent up. Though obviously emotional he is unable or unwilling or afraid, and he therefore denies expression of his feelings. Because he is obviously tense and unhappy we can but feel that somehow or sometime he must find expression, if only in a lonely outburst of tears. In such a personality the dominant impression is one of strain, and we wonder what inside struggle could possibly account for it.

How to explain this unwillingness or inability or fear of expression? Essential to its understanding is an appreciation of *anxiety*.

Fear and Anxiety

Anxiety is, of course, an aspect or derivative or manifestation of fear, but it must be distinguished from fear in several important respects. Confronted with immediate danger—and we may consider danger to be any tangible threat of frustration of basic needs – the behavior of the organism is expressed as a total physiological mobilization of forces for the purpose of dispelling the threat. This is fear behavior and is characterized by the emergent readiness for aggression or flight. Thus, as Cannon (25) suggested, there is to fear a function of utility in emergency. In fear the heart beat becomes more rapid. Blood is withdrawn from the abdominal spaces where it is slightly needed for action and supplied to the

limbs where it is needed in abundance. The animal afraid—human or otherwise—is alert. He is ready to fight or run.

Even in the child too young to fight or run, the physiological manifestations of fear are very prominent. At a sudden loud noise the infant's attention is immediately caught and held. At such stimulation even before birth the heart beat immediately accelerates, and the whole body responds with characteristic body startle (130, 131, 132).

As he develops there emerges within the child a feeling of fear—a sensation of sudden singleness of attention, of tension throughout his person, of readiness to cope with danger, and so a feeling of being afraid. In the presence of real dangers, the child early sees the relationship between his fear and the specific aspects of the environment that threaten loss of security. He learns *what* in the environment is dangerous. The child of eighteen months may respond with a typical body startle to the sudden bark of a dog, but he is not necessarily afraid of dogs. However, a particular child at six years may indeed be afraid of dogs—at the sound and sight of a dog two blocks away. For the older child the feeling of the emotion of fear has emerged together with a concept—in this case "dog"—of what in the environment is to him a threat.

We see, then, that fear represents at once a suspension of activity and a preparation for activity in the direction of greatest utility to the threatened organism. The individual may or need not realize that he is afraid or know specifically to what in the environment he thus reacts so totally.

Immediate dangers in everyday life are usually handled so automatically that they are dispelled before the individual is aware of the threat. The automobile driver, narrowly averting a crash, realizes only afterward the true nature of the situation. By the time he does, however, he feels tense and is aware that his heart is beating rapidly. The threat having been dispelled by his successful maneuver, gradually he returns to normal. His total reaction of fear has served its function—it dispelled the threat to self-preservation.

So much for the fear that serves its purpose. But what of the fear that is not expressed in action? Consider the experienced driver. Under optimal conditions he exercises caution automatically, without being aware of it. He reveals and experiences fear only in rare emergencies. Submit this same driver to the task of driving in fog or on a dangerous and unfamiliar mountain road. Now the threat

of potential danger is well appreciated—he is aware of it. His behavior becomes more than cautious. Required thus to carry on for an extended period, he becomes tense and aware of tension within himself and aware ultimately of the fatigue that follows continued strain. Mobilized for action as he was in the sudden emergency, he has here been maintained in a continued condition of readiness to cope with the threat of danger.

It is true of soldiers before and during combat that fear as such is experienced most intensely and dispelled most readily when face to face with the enemy, for in this situation the man executes, as it were, the action for which his person has been prepared by fear. In the weeks and months of preparation for combat, while awareness of danger not yet met assumes greater and greater reality, the individual experiences physiologically the feeling of fear but without the possibility of dissipating this emotion in appropriate action. Thus, the more remote the threat of danger, the more sustained the fear, and the more sustained the fear, the more pervading is its influence on the personality, physically and mentally. Under conditions of sustained and undissipated fear—for which the term *anxiety* is used—the individual is left in suspension, and his behavior becomes more and more nervous. Perhaps quite unaware of fear, he tends to worry about minor things; he becomes unusually aware of vague bodily sensations. He becomes irritable, unduly sensitive to noises of everyday life. Because of the very remoteness of the source of danger, he usually fails to realize fear at all and feels only general distress.

We see, then, that the anxiety expressed under conditions of remote threat to the ego need for self-preservation is a derivative of the fear experienced when danger is very apparent and real and immediate but that anxiety, much more than fear, is diffuse and is revealed in many subtle changes of the personality. We see also that as the opportunity is denied for the individual to act to dispel danger the fear becomes anxiety. The individual is frustrated because of his very inability to do anything to ward off the threat to his security. Thus, anxiety may be considered to be a state in which emotional control is suspended. Consciously, the anxious individual is uncertain and worried. He cannot find a solution to his problem, no matter how much he thinks about it. Lacking the promise of success, he is afraid to act.

The normal person often experiences mild anxiety in new situ-

ations, a new job, a strange city, and strange people to meet and know. The first plane ride is exciting even in anticipation. During the war, anxiety was revealed by many men, not primarily at the prospect of death, but because of removal from the regularity of life at home, where daily problems were handled automatically. Many a married recruit was anxious at removal from the security represented by his wife. In the complicated pattern of social life today anxiety is a frequent phenomenon of normal living. Useful as it is in sudden emergency, man's automatic fear reponse loses its biological appropriateness when aroused by fancied or anticipated catastrophe rather than real danger. The dread of examinations, worry over finances or the illness of a loved one—such natural behavior is sometimes so pervasive as to distort sleep and digestion and social life and adjustment. In no way does it serve to dispel that which threatens, for such problems are not solved by simple aggression or flight.

By its very nature as a state of suspended readiness for aggression or for flight overt anxiety is a social phenomenon, for it denotes a preparation for dealing with the environment. When we observe clinically the outward signs of anxiety—restlessness, tremulousness, tachycardia, irregular breathing, increased perspiration, particularly of the palms—we therefore look for some failure of the patient to find security in his environment, some frustration of the need for love and ego recognition, a need that is essentially social.

Because of its impermanency and because it represents no real solution to the patient's problem, overt anxiety is rarely maintained for long; some active solution emerges to relieve the tension. The nature of the particular solution found is an expression of the whole personality pattern of the individual. In the face of catastrophe for which there appears no solution—bankruptcy, failure in college work, death of an overprotective parent—the individual often suffers breakdown—inability to continue on the job. His vague complaints of weakness and sleeplessness, his indigestion and stomach pains now become intensely real; they serve as a justification for his incapacity. The nervous breakdown crystallizes as an illness, deserving of sympathetic treatment, reassurance of protection, and care and love. Often, as we shall see in the later discussion of inadequacies of control, such illness becomes so real that it culminates in actual tissue damage and is expressed in serious physical disease. It is known, for example, that in both normal subjects and patients with

peptic ulcers, gastric acidity and stomach contractions may be increased by anxiety, hostility, and resentment (147).

The individual who has been frustrated by the environment finds, through illness, reassurance of security in his environment. His state of anxiety has been reduced by the achievement of a solution—inadequate though it is because it is incapacitating—to frustration of need for social recognition and acceptance. Such solutions have been termed *psychosomatic*, suggesting that certain physical symptoms are psychologically determined.

In the discussion of anxiety thus far, its psychogenesis and the means by which it is often dispelled have been considered referable to frustration of social need of the ego. But what of those frustrations of expression that stem not from environmental rebuff but from the individual's denial of his own impulses? We shall see in the later discussion of maladjustments that certain frustrations are associated with conflicts within the individual that make free expression impossible or catastrophic. Unacceptable to the individual, these basic urges for expression must be repressed. In many cases of such inner conflict overt manifestations of anxiety are lacking. This does not mean, however, that in the psychogenesis of such maladjustment anxiety is not important. To understand the significance of anxiety in such a case, it is necessary to consider the development of a solution of anxiety characterized not by a social solution but rather by the *avoidance of frustrating circumstances.*

Introversion

From the individual's point of view, adjustment might be summed up as a proposition of fitting one's individuality, one's self, into the social pattern—a matter of doing one's part, yet expecting society to make concessions when necessary. On a party, the fellow who is hungry may feel that the gang should leave the dance and get hamburgers, but he is willing to wait until they are ready to go along. If he is hungry enough, however, he may leave the party, preferring for the moment to satisfy his hunger rather than his social need.

In the adjustment to the reality of the world one must make concessions of one's individuality. Behavior that reveals sensitivity to the demands of the environment and motivation toward submergence of the individuality has been called *extrovertive* behavior. Such behavior originates *socially* and is oriented toward social expression.

The child, like the traditional psychopathic personality, is supremely egotistic; he seeks socially the satisfaction of basic needs in impulsive demands upon the environment. He is essentially, therefore, extrovertive, a fact clearly revealed in his frequent attention-getting behavior. As he develops, however, he finds that uninhibited expression often leads to unpleasant consequences and that, of the activities that are interesting, at least some are forbidden. Frustrated occasionally in attempts at self-expression, he is sometimes anxious and unhappy. These frustrations often lead to doubts about the validity of normal impulses, and he attaches to censored or forbidden activities a moral significance of wrong. Forbidden, they must be put away from the mind, repressed, thrust out as evil.

This early experience of frustration and repression is universal in human development. It is by this means that moral principles are acquired as necessary forms of control. But what is the effect of frustration on the child and on the later pattern of personality?

Frustrated environmentally in the expression and satisfaction of basic impulses, the child seeks substitute satisfaction in fantasy and in the dream world—*i.e.*, satisfaction, independently of the environment, within himself. He fancies himself a policeman with great power, a gunman who achieves love and fame simply by his self-assertion. In so doing the child finds substitute satisfaction in a world of his own, in which he is central—unlike that outer world to which he is peripheral. We see in such tendency the emergence of *introversion.* Introversion in contrast to extroversion is characterized by an avoidance of environmental demand in concession to one's individuality—a turning, when the outer world fails to satisfy basic needs, to resources within. It is in the self-world that great dreams are made and from which constructive and creative contributions emerge. Through introversion are developed those resources within the self—of reflection and introspection and self-understanding—so necessary in tiding the individual over the rough spots.

Thus, we see that the normal anxieties of childhood are often relieved early by fantasy and later by creative activity—activity from within. Although such recourse to the inner life may seem on the surface to be an avoidance of the world, a flight from reality, the individual by such substitute activity dispels the readiness for action—for aggression or flight—that typifies his earlier anxiety. In the older individual who is troubled not by social con-

flict but by the inacceptability of urges within we do not see characteristically the overt manifestations of anxiety such as tremulousness and hypersensitivity. But in such a person the inner aspects of anxiety often emerge—self-doubt and discouragement, dejection and depression. In the extreme, such an individual may be given over almost wholly to introversion, so that to him the outer world means virtually nothing. When viewed from without, emotional responsiveness and mood often seem inappropriate, for they are expressions not of reactivity to environmental stress but to stress from within, from the individual world we do not know. Hence it is that in severe maladjustments the mood of the patient is of importance in understanding the nature of conflict.

Clinical Methods for the Study of Control

When in our effort to evaluate the individual we direct our attention to factors of control we can be guided by the following general questions:

1. Is the individual able to function at the full level of his capacity? If so, there is no problem of psychopathology.

2. Unable to function at full capacity level, is it because in his attempts to achieve emotional security the individual is at present frustrated? Is he repressed or anxious? or

3. Is function reduced because the individual has developed an incapacitating way of achieving emotional security?

4. Does the incapacitating manner of achieving emotional security represent an attempt as by physical symptoms to justify maladjustment socially? or

5. Does the incapacitation represent really a disregard for social justification and rather the elaboration of an inner, more congenial world?

In evaluating control our problem is essentially the task of setting up a hypothesis to explain dynamically the individual's behavior. If we knew all we needed to know about his history, we should require only a superficial acquaintance with his present behavior. However, the most important facts about the patient's history are usually just those facts that are hidden not only from the clinician but from the patient himself. For this reason the clinical study of the patient's behavior is of much importance. In his present behavior, in his ways of responding to the clinical situation, in the solutions he achieves for the problems presented in

interview and test, we find clues to patterns earlier utilized in meeting more vital frustrations.

Although interpretation of the patient's present adjustment in the light of its developmental dynamics is today the procedure usually urged in clinical practice, this emphasis is relatively new and differs rather sharply from clinical procedures that for many years were classic. As was pointed out in Chap. II, until recently the interest of the clinician was primarily in the syndrome presented by the patient. If on the basis of examination alone the clinician could diagnose *dementia praecox* there was little or no need to go into its psychogenesis. Evidence that the patient heard voices telling him to kill his grandmother or that he had a system for automatic sterilization of all red cows—these because they meant that the individual was out of touch with reality were sufficient to warrant the diagnosis of insanity. Insanity might be evidenced also by incoherence or irrelevance of speech, "word hash," etc. Thinking psychologically in such terms, it was convenient for the clinician to have in his armamentarium a list of signs and symptoms, such that from the presence of several of these indicators he could compound a diagnosis and so establish the course of treatment.

The natural result of this syndromic orientation was the development of a rather standardized procedure of clinical study. By examination of perception, thinking, memory, affectivity, etc., the clinician sought to elicit whatever in the patient's present condition indicated mental disease. Whereas our fundamental interest is in how the patient achieves emotional security and only superficially in the unusualness of his method, the earlier interest was in whether the patient (incidentally seeking security) behaved pathogically.

In the present discussion it is urged that the clinical examination be considered as a test situation, to which as the clinical study proceeds the patient's adjustment repeatedly may be evaluated. The situation is such that by informal manipulation the clinician may test those aspects of the personality that at any point remain uncertain. In uncontrolled observation he obviously learns many things; in the clinical setting even though it may go unnoticed no fragment of behavior is unimportant. In the patient's appearance and walk, the way he uses his hands as he talks or keeps them idly in his lap, the energy with which he strides about the room, the care of his person—in such the clinician finds many half-formalized clues, clues that serve as leads for further investigation.

In appearance, for example, introversion may be suggested by the asthenic body type, by careless attire, or by oddity of dress. On the other hand, intense involvement with the present environment might be revealed in good taste in dress and manners or in flashy clothes and jewelry. Homosexual trends often are suggested in clothes and manner.

Of considerable significance is the patient's behavior in the initial breaking the ice with the clinician. Is his social awareness revealed instantly in his embarrassment, in his resentment and evasiveness, in his sophistication? Or is he calm? Does this calm stem from cultivated poise—breeding—in an individual nevertheless warmly aware of his immediate environment? Or is his calm simply a further feature of detachment and preoccupation with other things, actually evidence of a disinterest in the present situation?

Anxiety is revealed particularly in overt undirected behavior, for the anxious person is physiologically expressive. Ill at ease and unhappy, his tension is expressed in restlessness and often in open tremor. Autonomically anxiety is revealed in irregular breathing and in excessive perspiration and sometimes blushing, and because the patient's entire behavior is pervaded by tension within he may stammer; thus, even though his attitude may be one of cooperation and a desire to help the clinician as much as possible, his distress is obvious.

The patient's voluntary speech—is it cautious, defensive, guarded, suggesting repression and tension? Or, taking the initiative, does he pour out his heart to you in the first few minutes? Does he seek to impress you with 10-dollar words or with involved sentence structure or to reassure you that everything is fine? Is speech difficult? Or like his appearance and manner does his speech reveal a basic disinterest and detachment? Does the patient bring up irrelevant matters, go off on a private tangent?

How responsive is the patient as the interview proceeds? Does he show a change? Does he maintain rigidity, refusing to yield to the warmth of a new friendship? Or does he gradually melt? Do personal questions arouse embarrassment? Is embarrassment exaggerated? Do you receive the impression that in regard to intimate matters there is a heightened tension and reserve? What topics seem to be most enthusiastically received, most embarrassing, or most saddening? Does discussion of the death of a parent seem to bring out appropriate sadness, or is the emotional response

inappropriate? Impressions that the patient's emotional response is inappropriate in any way—less or more than you expect, or different—these reveal the adequacy with which in everyday adjustment emotion is successfully functional, and they are therefore of considerable significance.

In the oversensitive or overreactive person, as long as the emotional response is appropriate we can be assured of outwardness, or social awareness. The introvert may reveal intense emotionality, but this emotionality is in key with his own world and not responsive so apparently to stimulation from the outside. Consequently, he may appear emotionally flat. His response to provocative stimulation may appear inappropriate in degree as well as in kind. Discussion of his sexual life, for example, may be as matter-of-fact as discussion of the stock market, and he may talk quite unemotionally about seeing the death of a loved one.

The Patient's Attitude toward His Present Situation

It is human nature for man to view his present situation as the best possible adjustment under the circumstances. Seldom is he aware of maladjustment within himself; rather, in a pinch, he is aware that the circumstances have become difficult. For the child the situation becomes difficult when he receives punishment and reproof and is denied impulsive expression.

To the extratensive person, whose behavior is determined to a great extent by social forces in his environment, the symptoms of physical illness afford an excellent excuse for incapacity. The person who is obviously ill is not expected to function at his best.

In evaluating the dynamics of the patient's present situation it is important to understand his attitude toward it. Does he feel that there is actually nothing wrong—that his adjustment is satisfactory? Is his attitude such that, after all, factors in the environment are impossible—not he? Does he feel, like the child, that others are to blame for his difficulty? Or in his inability to understand his predicament do you detect the introvert's devaluation of the environment? Does the patient consider himself sick? What is his *chief* complaint—and what else bothers him? Is he absorbed intensely in his illness? Is it something he accepts as an established fact of obvious interest to the clinician? Does his illness pervade his whole personality as the dominant theme of his present situation? Is there a single, well-fixed symptom, such as gastric pain? Or are the

symptoms multiple and vague? Does the patient shift from one complaint to the other, thus giving the impression that the nature of the symptom is actually less important than the establishment of its existence? Do you get the impression that the patient is well adjusted to his symptoms—perfectly reconciled, at least for the present, to being an invalid?

Nature and Onset of Illness

If physical complaints are in evidence, when did they first appear? What was the individual's life situation at the time? Did illness appear suddenly? What associations does the patient have with its onset?

Had the patient known similar complaints in parents or in others with whom he lived? Is there reason to suppose that the patient early in life observed invalidism and learned its security value? Is there evidence of chronic illness or of an illness or accident habit? Finally, can you reconstruct the patient's situation at the time of onset of illness in such a way as to make the inference that it developed as a solution to a problem he then faced?

Test Procedures in the Evaluation of Control

In the discussions of both capacity and motivation it was emphasized that, because of their crudity and limited range, procedures such as interview and observation are often inadequate and the clinician is sometimes able to detect signs of gross maladjustment only by means of more refined measures such as tests. Particularly with respect to emotional factors is the limitation to interview and observation often unsatisfactory if not fruitless, for in the face-to-face social relationship of the clinical consultation the patient's defenses, acquired often over years, are most effective as screens of the personality. This defensive barrier often creates a stumbling block even for highly trained clinicians. The following cases are illustrations of the unique value of test procedures in diagnosis.

Regarding minor variations in the pattern of performance on the tests of his Bellevue Scale, referring to what he calls "soft signs" (deviations in test score that are slight but in the direction of those met to a greater extreme in certain disease entities), Wechsler (143) describes the case of

. . . a nineteen year old boy who was admitted to the hospital after an attack of dizziness and transient loss of memory. He had experienced several similar attacks before, which the mother described as of short duration. She said, "He (the patient) did not seem to remember and couldn't get himself together." The only event which the patient himself associated with his last attack was that on the night before he had "drunk two coca-colas." A neurological examination on admission was essentially negative. He improved very quickly and was discharged after a short period of observation with a tentative diagnosis, largely based on the patient's attitude toward his illness, of conversion hysteria. During this first stay a psychometric examination (Bellevue Adult) revealed a number of "soft signs" which led the psychologist to suggest the possibility of organic involvement. As there was no medical substantiation at the time of an organic brain disease, no special regard was paid the psychologist's observation. Three months later the patient was readmitted to hospital with a fullblown brain tumor. (Page 157.)

Hill and Hildreth (67), reporting five military cases of what they described as "Hidden Dementia Praecox," may be quoted as follows:

The outstanding fact of interest in all cases was the extent of the schizophrenic pathologic state, which, without the psychometric examination, was not evident. It may be that their military routine with its emphasis on suppression of individual aggressive drives aided in concealing their symptoms. The fact that four of them were Negroes may be significant. Whatever the explanation, the dementia praecox was extremely well hidden. Had these patients been returned to civil life or to duty, it is likely that at least one would have committed other acts of violence before the dementia praecox was recognized.

Case report.—An 18-year-old Negro, a steward's mate, third class, in good physical health, was admitted to this hospital because for six months he had been a disciplinary problem, having received four brig sentences, and for the previous three months, he had been in a brig for safe-keeping. There he was a continual source of annoyance to Marine guards because he frequently assaulted them without provocation.

The psychiatric examination, which lasted 1½ hours, elicited only that the patient was dull and evasive; his parents had been separated for several years because of his mother's alcoholism; he stammered since childhood; and he never had had a gainful occupation except occasional farming.

It was curious that so much time could be spent with a patient without obtaining data for a psychiatric diagnosis; therefore, a psychologic consulation was requested.

The psychometric examination showed a borderline intelligence with 15-percent deterioration at the time of examination. After the intelli-

gence tests had been given the patient admitted to the psychologist in the presence of the psychiatrist the following data which, with the psychometric examination, gave evidence for the diagnosis of dementia praecox: For more than a year the patient had experienced auditory hallucinations which directed his conduct; he had struck Marine guards at the instigation of the voices; and voices also told him to paint a Rising Sun on his helmet, to wear a gas mask, and, thus attired, to eat at the officers' mess. (Page 486.)

Questionnaires and Inventories. Of the testing procedures that have been developed for purposes of getting at factors of control, mention should first be made of paper-and-pencil techniques. In a limited way simple Yes—No questionnaires are often useful as first samplings. None of the personality scales of this questionnaire sort so far devised is so foolproof that it cannot be falsified deliberately by the patient in ways that may disguise his real attitudes and feelings. Low scores on such scales cannot therefore be taken to mean *ipso facto* that maladjustment is absent (just as low scores on intelligence tests cannot be considered diagnostic automatically of low capacity level). However, pathological scores on such personality scales, even though sometimes the result of deliberate distortion, are always of interest for they suggest maladjustment even if indirectly.

In order to obtain scores for various psychological variables, there have been many attempts to summate and weight on such tests the number of single atypical answers. Two such attempts already mentioned in the discussion of tests of motivational factors are represented by the Bernreuter (15) and the Minnesota Multiphasic Personality inventories (59).

The Minnesota Inventory is designed to render easy the selection of the items of greatest clinical interest, *i.e.*, the items answered atypically. It provides the clinician automatically with cards sorted atypically as "True" (about me) or "False," or "Cannot Say." Scores are obtainable for variables not so much those of basic motivational patterns as of patterns significant in the light of conventional categories of psychopathology, such as tendencies toward psychopathy, hypochondriasis, hysteria, psychasthenia, depression, hypomania, paranoia, and schizophrenia, as well as for masculinity and femininity as discussed in Chap. VIII. Based on the patient's unusual or uncertain answers three supplementary scores give some suggestion as to whether he is fully reliable in his

performance of the test. Among the scores for pathological variables there is apparently some degree of intercorrelation. Many of the items contribute toward scores for more than one variable.

The Minnesota scale is, in our opinion, the best of the exhaustive questionnaire-type scales; it is that most readily used by the patient and most easily scored; it permits a focus clinically on those answers that are of most interest, *i.e.*, the atypical answers. Moreover, in clinical practice the qualitative examination of these atypical answers is often of greater utility than are the quantitative scores.

Projective Methods in the Study of Control. It was pointed out in the discussion of procedures for the clinical study of basic motivational patterns that projective techniques often penetrate beneath those defenses which obscure the personality picture obtained only from interview and the questionnaire-type test. The very defensiveness of the patient is, of course, an operation of control, and it is therefore understandable that projective techniques are extremely useful in revealing the nature of the defenses themselves as well as of those aspects of the personality they obscure.

Of the projective techniques available for the study of control factors, none has received more attention and wider usage than the Rorschach *Psychodiagnostik* (119). The 10 ink blots finally adopted by Rorschach are now standard, so that when one finds reference to the Rorschach experiment or the Rorschach test it may be assumed that the procedure is that recommended by Rorschach or some derivation of this procedure developed by one of a small group of his successors. The utility of the Rorschach method or any other projective device is a function, not so much of the test material, as of the manner in which it is used and the clinical point of view from which interpretation is made. The point of view applied to the Rorschach record can be applied as readily to the patient's response to any other stimulus material. We have assumed throughout this book that any test or observation is simply a setting in which the patient is faced with a problem, his personal solution to which is to be considered an expression of his past experience and ways of reaction. The stories told by the patient apropos of the thematic apperception pictures may be interpreted similarly, as may his dreams and daydreams—even his daily behavior. The studies of Balken and her colleagues (7, 8, 9, 96) have emphasized the diagnostic value of the Thematic Apperception Test in a wide range of neurotic and psychotic personalities, both adults and children. We

shall see in the discussion of maladjustments associated with inadequate control how the fantasies as revealed in the stories are of interpretive significance.

The Rorschach Method in the Study of Control. Compared with methods such as the Thematic Apperception Test and play techniques, which involve interpretation of the patient's productions in terms of fantasy, the Rorschach method differs most in that it focuses attention on the nature of the patient's perception. It may be suggested again that in the series of 10 varying forms there is a wide range of differences. Each of the forms is relatively strange and unfamiliar. Some are definite, some diffuse. Some are highly colored, some gray. Naturally, different aspects of the blots will have differing stimulation value for different personalities. Some persons will be warmly sensitive to color values, others untouched by them. For some the clear outline of the figures may be salient, while another individual may reveal greater freedom of expression when form characteristics are vague.

In the Rorschach situation, then, asked only, "What might this be?" the individual is left entirely to his own devices; he is given no clue as to what is needed. He has no idea just what he should do to make the best impression—Should I look for much or little? Should I turn the blots upside down or hold them upright? Will I look foolish if I say this looks like a bear? The patient is thrown entirely on the resources of his own personality. In this foreign response-demanding situation the individual is confronted with a problem of adjustment quite analogous in its loneliness and helplessness to those life situations that tap the very core of motivation, capacity, and control. Confronted with the ink blots the patient may be immediately participatory, losing himself quickly in the spirit of a new game. The strangeness of the material may perplex him. He may feel immediately "on the spot"—inhibited and wary—or he may maintain an attitude of detachment or of abstract and formal interest in the rather unusual material. Thus, in his total behavior in the Rorschach situation, the patient obviously may reveal trends of anxiety or of repression or of introversion—evidence that supplements the material gained from interview and observation.

Most of our present conceptions of what is revealed by the individual Rorschach responses and their summarization is derived from extensive clinical studies of Rorschach himself (119) and of his successors (14, 64, 81, 108).

In any discussion of Rorschach methodology it is important to understand that, although in the development of the technique many detailed aspects of the performance have been stressed, clinical interest is focused on the total picture provided by the performance. Technical refinement in detail has been directed almost entirely toward further validation of the total picture.

It is in the evaluation of the patient's general response to the Rorschach situation and particularly in the examination of the single responses given by the patient that the clinician is able to confirm or readapt his "hunches" as to the essential characteristics of the personality.

Development and the Rorschach. In understanding the significance to the total picture of various aspects of the Rorschach performance it is helpful to examine their pattern of development in normal childhood[1] and the variations in pattern that suggest distortion. The following seem to be fundamental developmental trends:

1. With age the child becomes more productive: he gives more responses and the qualifications of his responses become more elaborate.

2. Early in childhood the individual responds frequently to the whole ink blot, while with age he uses more and more fine detail and rare combinations of detail.

3. His responses become with age less stereotyped and more original. Early in life the child tends to see more what others see (popular responses), and, while with age he normally retains this capacity, his apperceptions are determined increasingly by his individualized life experience, so that he tends to give more original responses. Irrespective of age, animal forms are frequently used. Tendency to stereotypy is most characteristic of the child and decreases normally with age.

4. Of the qualities inherent in the ink-blot material itself the most obvious and frequently used is form. The most dramatic stimulus quality, however, is color in the figures II, III, VIII, IX, and X. A more subtle stimulus quality is texture. With age there is a decreasing tendency to use color directly and an increasing tendency either to use it in combination with, but secondary to, form or to neglect it entirely. Thus where the child gives responses (as "grass" because the blot is green), or color-form responses ("a picture

[1] For material regarding the Rorschach in childhood and adolescence the student is referred to refs. 64, 78, 80, 142.

painting"), the older individual tends to restrict himself to form alone, or in using color to use it secondarily in form-color responses ("a flower" because of shape, but also because it is colored). We see then that age is characterized by a less direct capitalization on environmental potentialities (color) and a more formal incorporation of them into less expressive and reactive patterns (combining color with form). Maturity is characterized by the individual's gradual integration and ordering of environmental potentials.

Five of the 10 ink blots are achromatic. Any use of color as such on these is, of course, a use of black or white or gray. Although there is as mentioned a tendency for the young child to use bright color directly, the child gives few achromatic color responses. With age, however, there is an increasing tendency to use the color qualities of the gray blots, perhaps because for the child the potency of the bright color on the chromatic cards is in such a contrast to the achromatic shades that the color quality of the latter is relatively impotent.

The use of texture (as in seeing a furry object) also reveals the utilization of a quality which, like color, is inherent in the ink blot itself. Like the color response, the texture response denotes a reactivity with the outer world of the present environment. Like the use of gray or black color, the texture response is made usually to the achromatic cards; this response is rare in young children and is found increasingly with age.

We see, then, that in contrast to adults young children tend to use bright color more directly and that when color is absent, as on the achromatic cards, they restrict themselves to the use of form. The older individual tends even on the chromatic cards to restrict himself to form or some combination of form with color, but he also begins to utilize, in addition to bright color, sensory qualities such as black-and-white as color, and surface texture. These tendencies seem to be a refinement in the degree to which the individual permits himself to react with the environment. They reveal behavior that, directed no less outwardly toward the environment, is more cautious and tentative, more reserved and tactful—behavior that is more civilized.

The patient's sensitivity to stimulation from without is revealed not only in his utilization of color, but as well in the degree to which his response is affected by the *presence of color*. Even when color is not at all utilized directly, responses to the chromatic cards by

comparison with those to the gray cards are often more immediate or better qualitatively or more abundant; or they may be fewer or poorer in quality. In the presence of stimulation from without, the individual thus is found to function differently than when left to his devices, and to the extent that this is true we also thus recognize environmental awareness or extratension.

5. In contrast to the utilization of sensory qualities of the ink blots themselves, we often find a projection by the individual into the configuration of his response certain qualities that are not really inherent in the material: the prototype of this projection is the *movement* response. When the individual sees figures in some dynamic relationship between them or with respect to some outside force or even statically in some spatial reference to himself as an observer, we can detect projection of the self into the ink-blot material. In the movement response something is *happening*. Such a response represents a manipulation of the environment, and thus it characterizes the introvert. Responses less expressive than movement but still in this introvertive direction are represented in the projection of third-dimensional qualities: the patient sees an X ray, a topographical map, a landscape. Such third-dimensional responses are manipulations of reality, but they are more reflective or more tentative than the open projection of movement, and they represent, therefore, an adaptation that is more refined and civilized.

In the responses of children we find generally less projection than in adult responses. The child's movement, for example, is likely to be movement of animal figures rather than human figures (they naturally see animal more frequently than human figures). The most spontaneous adult projection is found in human movement responses, normally in excess of animal movement responses. Inanimate movement (such as a cyclone) or tentative or arrested or passive movement (such as "hanging" or "trying to") is revealed increasingly with age and implies a restraint in spontaneity. Third-dimensional responses, such as X-rays and maps, and the frequently seen "clouds" are given particularly on cards where color is absent (the achromatic figures). Rare in children, they are given increasingly with age.

We see then that at the introvertive pole freedom of activity within is characterized in childhood by the animal movement response, a type of response that seems to express the impulsive urges of childhood. This childish tendency gives way as develop-

ment proceeds to a tendency toward human rather than animal movement and toward the restraint of movement.

Constriction and Dilation. It has been suggested in the foregoing discussion of developmental patterns of the Rorschach that maturity in some measure is expressed by the degree to which the individual's emotional involvement with the environment and his expression of basic impulses is tempered by formalized control, as revealed in the combination of color and form, in the replacement of animal by human movement, or in more reflective forms of projection. We have shown how control develops as a refinement of response. But what of the individual who restricts himself to pure form, who uses no color, no texture, and reveals no projection at all? This is a pattern found sometimes in children and often in adults. The patient's general attitude toward the problems presented by each card and his differential use of chromatic vs. achromatic figures often reveal that he is sensitive to the varying potential of the cards serially, but, as shown by his use only of form, he does not permit the expression of his full use of the blot's potentialities. Such an individual is considered *constricted.* Constriction is accompanied usually by sterility of response, as shown in rejection of some figures, and few total responses. This is not always the case, however, for constriction may be accompanied by a sudden outburst of response to a particular card.

Dilation is the term used to characterize the Rorschach picture, which, in contrast to constriction, is one of considerable spontaneity, whether in the introvertive or extratensive record. When the percentage of pure form is greater than 75, constriction is considered to be indicative of extreme repression. When it is less than 50, the individual is considered to lack at least repressive control, and in the absence of other signs of control, he is felt to be unduly reactive emotionally.

Balance between Introversion and Extratension. We have seen that introversion in the Rorschach is represented in the individual's tendency to project into the ink-blot material qualities that are not essentially inherent in it, tendencies that represent therefore some manipulation of reality. Extratension, on the other hand, has been considered to be revealed, not only in the individual's use of color, but more importantly in his sensitivity to it, whether he uses it or not. We expect to find in the well-adjusted individual a balance between these poles of introversion and extratension. Four indices

have been suggested by which the degree of balance may be determined. Two of these indices derive from the nature of the single responses when totalled, while two derive from the individual's differential reaction to the chromatic vs. the achromatic cards.

1. Rorschach originally suggested, as an index of introvertive tendency, the ratio of the number of movement responses to color responses. For this he proposed the following formula: M:C, where C is calculated on the basis of 1.5 for each pure color response, 1.0 for each response in which color was used primarily together with form, and 0.5 for each response in which it was used together, but secondarily, with form.

2. The second ratio, proposed as were the third and fourth by Klopfer (81), is the ratio of animal movement plus inanimate movement responses to the sum of gray color and texture responses.

3. The individual's tendency to give more or fewer responses on the brightly colored cards (VIII, IX, and X) is expressed as a ratio of the total responses on these three cards to the total for the other seven, a ratio that is of interest if it exceeds 40 or is less than 25.

4. The last index is determined by comparing the time required for the first response to the chromatic cards with that to the achromatic cards. Unless disparity is great, this index should be regarded cautiously.

In this brief discussion of the Rorschach method it is suggested that by means of the test the clinician may verify his impressions of emotional stability and particularly of factors in the personality pattern that are contributory to it. Patterns of immaturity, of repression and anxiety, of oversensitivity to the environment and emotional involvement with it, or of exaggerated retreat from reality—these basic patterns, extracted and compounded from the single responses and the patient's total reaction to the situation, are revealed in the total Rorschach picture.

CHAPTER XI

APPRAISAL OF CONTROL—II. ANXIETY AND ITS SOLUTIONS

We have seen in the previous discussion that the individual's adjustment is at any given moment a reflection of his personal solution to the problems confronted in everyday living, problems that are in essence frustrations of minor or of real significance. The individual who solves his everyday problems in ways consistent with his functioning as a useful member of society we consider well adjusted; his solutions to frustration are successful. The means by which the adjusted individual achieves satisfaction of basic impulses without conflicting with the demands of society are the marks of adaptive behavior. These ways of harmonizing impulses with social reality we can consider essentially modes of emotional control. We saw that the psychopathic personality, which could be called infantilism, was characterized chiefly by defect or deficiency of these very factors of control. It is the purpose of this chapter to discuss other forms of maladjustment, particularly as they seem to reflect the exaggerated or distorted or weak functioning of controls. In some of these maladjustments the immaturity of the psychopath—lack of control—is sometimes apparent. But, though no more desirable than the psychopathic, these forms of maladjustment are less infantile in one important respect: they are focalized on the *anxiety*, a characteristic that is found in the psychopath only superficially if at all. Like the child, the psychopath is rarely anxious for long. His immediate response when tried or frustrated is to move impulsively toward the goal—to grab what he wants, fight when angered, run when frightened. He lacks the maturity characterized by doubt and apprehension and anticipation. These require judgment and forethought.

Anxiety State

It was suggested in earlier discussion that as response to frustration anxiety is a condition of extended or protracted preparation for

action; it is a tentative suspension of activity, a readiness—in one direction or another—for release. It is thus a state of tension. Since anxiety is a condition highly intolerable to the individual, usually it is quickly dispelled. In some instances, however, it is so persistent and so pervading that the individual is largely incapacitated. To designate this incapacitating severity of anxiety the term *anxiety state* is used.[1]

It will be recalled from Chap. X that the anxious individual functions physiologically in a state of extended fear. He is irritable, hypersensitive to noise about him, restless, and uneasy. He tends to perspire freely; his breathing is irregular. He suffers digestive upset, diarrhea, a tendency to urinate frequently. He is aware of vague bodily sensations, increase of heart rate, nervousness. He sleeps poorly. Important in the very initiation of anxiety state is the patient's inability to understand fully the nature of the circumstances that are frustrating—the urges within himself that seek expression and the environmental barriers that prevent expression.

Characterized by an increasing distress, anxiety state is revealed in the patient's increasing worry and his absorption in the problem of his incapacity. He magnifies the importance of physical complaints. Because his problem itself is vague, he is unable to formulate his worry into a logical pattern of thinking. He has difficulty making decisions; uncertain of success, he avoids decisive action. Because of these characteristics of lack of focus and of diffusion, of tentative, undispelled suspension, severe anxiety is often referred to as "free-floating" anxiety. When it is so severe as to stand out as the prominent aspect of maladjustment, anxiety is found to follow frustration of recent rather than remote significance. In this respect anxiety state differs from almost all other pathological syndromes.

The clinician's task in the case of severe anxiety is to make an analysis of the patient's present situation in terms of the urges that seem to need expression and the outlets that are presented for their expression. Although it may occur at any age, anxiety state is found usually in adolescent or mature individuals—persons whose normal, fairly civilized pattern of life has been somehow interrupted and who are at a loss to readjust. Severe anxiety eventuates often

[1] To refer to this condition of incapacitating anxiety, the term *anxiety neurosis* is often used in the literature. However, as we shall see in later discussion, the term *neurosis* is best considered to refer to a form of reduction or elimination of anxiety. Hence the term *anxiety state* is preferable.

as an expression of sexual frustration or following the death of a parent on whom the individual has been singularly dependent for emotional security.

In the fantasies revealed by the thematic apperception stories, Masserman and Balken (96) conclude that patients experiencing severe anxiety (whom they designate as "anxiety hysterics")

> . . . when first given the test, are, as a rule, apologetic for their "lack of imagination," but continue to be defensive in their reactions and guarded in their productions in response to the presentation of the first few pictures. However, the patients soon become much freer in their inventions, and then produce phantasies which are characterized by moving, dramatic situations and intense, comparatively clear-cut conflicts among the characters. Moreover, anxiety-hysterics readily identify themselves with the characters in their phantasies and thus the stories often assume a frankly autobiographical character. (Page 86.)

They report the following as an example:

> A middle-aged married woman in whom a state of anxiety-hysteria had been precipitated when an attractive girl relative had come to live in her home gave the following phantasy for one of the pictures:
> "It might be the landlady finding a dead body or something, only she doesn't look horrified enough for that. The dead body of a roomer—a suicide. The landlady might be worried because it happened in her house." (Page 83.)

The Rorschach reveals anxiety often in constriction; the patient reveals in his restriction to pure form an unwillingness to permit himself to be spontaneous. He hesitates to utilize aspects such as color. Anxiety is revealed often in the tentative utilizations of black color, and in the texture response. Most characteristic of free-floating anxiety are the weakly intellectualized responses such as maps or X rays, and in particular the diffusion response ("clouds"). The use of movement by the anxious individual is restrained; often the free and open human or animal movement is replaced by inanimate movement. Particularly when inanimate movement is coupled with diffusion, as in "clouds moving across the sky," do we find the extremity of expression characteristic of anxiety state (81).

Unsuccessful Solutions to Anxiety

Anxiety is dispelled by means of some solution to the frustration that faces the individual. Successful solutions are characterized by

readjustment. Certain solutions, even though they reduce anxiety, are nevertheless unsuccessful because they leave the individual incapacitated. In the eyes of society they are therefore undesirable and inadequate. It is these inadequate solutions that constitute the psychopathology of neurosis and psychosis.

The nature of the solution to anxiety that finally develops is a function of the source of frustration and the orientation of the individual, socially and/or toward himself. In the extratensive individual, anxiety arises because of social frustration. It is understandable therefore that its neurotic solution should be oriented socially, in the direction of excusing incapacity in the eyes of others. In the introvert, troubled more because of doubts as to basic urges within, anxiety is dispelled typically by solutions that are personalized and that need have only incidental relation to society. In a general sense unsuccessful solutions that are socially oriented are neurotic, while those that are personally elaborated are in the direction of psychosis. Because most individuals are both extratensive and introverted—*i.e.*, ambivert—solutions to anxiety usually reveal both social and personal elements.

In the following discussion of maladjustments we shall deal first with the socially oriented solutions and immediately thereafter with those that are so personalized as to be psychotic. Those that are admixtures of both social and personal elements—the group of personalities that form the bulk of cases of maladjustment—will be discussed in the next chapter.

Unsuccessful Solutions That Are Socially Oriented

It has been suggested that socially the most acceptable excuse for incapacity is obvious physical illness. In symptoms of physical disease the neurotic individual frequently finds solution to frustration and anxiety. Symptoms of physical illness to the extent that they are considered to be psychologically determined are considered *psychosomatic*. The mechanism by which the emotional tension of anxiety is reduced through the development of physical symptoms is called *conversion*. Many diseases in which actual tissue damage occurs—diseases such as gastric or duodenal ulcer, asthma, and even diabetes—are today considered to be at least in some part psychogenic and hence psychosomatic. Not all illness that is psychosomatic is socially obvious, of course, so that illness per se cannot be considered therefore always to be socially oriented. Of circu-

latory and cardiovascular diseases that are considered to be psychosomatic, those typified by heart attack and by stroke are found usually in the extratensive individual. These are paroxysmal, intensely dramatic, and obvious. Illnesses such as high blood pressure (hypertension) and duodenal ulcer, on the other hand, develop usually in the introverted individual, unknown to the patient himself as well as to others until openly recognized (37).

Of the organic illnesses that are believed to be in great degree psychosomatic, perhaps certain skin diseases, asthma, and hay fever—all related to allergies—are socially the most demonstrable and may therefore be considered most extratensive. In asthma, particularly, anxiety features are very prominent, its attacks being usually precipitated by emotional frustrations, such as loss of protection, that are fairly apparent.

Hysteria

Of psychosomatic illness that is socially oriented, the classic form is *hysteria.* The term hysteria refers to obvious physical disability for which no conceivable organic basis can be established and which is considered therefore to be entirely psychogenic. Hysteria, because it is the most obvious utilization of physical illness as an excuse for incapacity, is the prototype of neurosis. It is best illustrated by hysterical anesthesia, a condition in which the patient is truly insensitive to pain and in which the anatomical distribution of insensitivity, usually in an arm or leg, follows no conceivable organic pattern of nerve supply. In the hysterical "stocking-and-glove" anesthesia it is the foot or the hand that is anesthetic rather than the area supplied by some particular nerve. Another classic example of hysteria is found in certain cases of partial blindness. Partial blindness due to actual nerve damage is characterized always by a lopsidedness of the visual field; peripheral vision is restricted in certain *areas* of the field of vision. Partial blindness in which peripheral vision is found to be restricted uniformly, so that the entire field is constricted, could never occur as the result of damage to the nervous system; it is diagnosed, therefore, as hysterical.

Hysteria may simulate many diseases and be revealed in an unlimited variety of symptoms. The two hysterical manifestations mentioned—anesthesia and partial blindness—are, of course, *sensory.* Hysteria is often *motor,* revealed in restriction of movement and even

paralysis of muscles. It may also be characterized by periods of loss of consciousness, known as *amnesia.*

The hysteric usually accepts his illness as an established fact—something that is valid and to be reckoned with. He is rarely unhappy about it, essentially because through his symptoms he is relieved of anxiety and frustration. Hysterical solutions are almost always associated with sexual frustration at a fairly adult level—*i.e.*, frustration of normal heterosexual adjustment. Frigidity in women is a good example of hysteria. Hysteria frequently seems to represent an *identification* with a parent or loved one with whom the patient has been closely associated. It often follows a pattern of symptomatology similar to that observed in the loved person. Often, therefore, it is imitative. Hysteria is more common in women than in men, possibly because psychologically women are more passively extratensive than men.

Of utmost significance in the evaluation of hysteria is to determine just how, in the development of the patient's symptoms, frustration is reduced. In the acquisition of the symptoms presented, what problem of social adjustment is eliminated by invalidism?

Sixty of the items of the Minnesota Inventory contribute toward a score for *hysteria;* of these, 42 contribute also toward scores for other variables of psychopathology. The 18 remaining items that contribute toward hysteria *only* are:

Answered "True"

Much of the time my head seems to hurt all over.
I frequently notice my hand shakes when I try to do something.
I can be friendly with people who do things which I consider wrong.

Answered "False"

I have never had a fainting spell.
I have often lost out on things because I couldn't make up my mind soon enough.
I like to read newspaper articles on crime.
I enjoy detective or mystery stories.
I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others.
I feel that it is certainly best to keep my mouth shut when I'm in trouble.[1]
I am likely not to speak to people until they speak to me.
It is safer to trust nobody.
I frequently have to fight against showing that I am bashful.

[1] Also contributes toward score for masculinity-femininity.

I resent having anyone take me in so cleverly that I have had to admit that it was one on me.
Often I can't understand why I am so cross and grouchy.
I get mad easily and then get over it.
In walking, I am very careful to step over sidewalk cracks.[1]
I commonly wonder what hidden reason another person may have for doing something nice for me.
The sight of blood neither frightens me nor makes me sick.

The following four items represent an overlap between the variables *psychopathic deviate* and *hysteria* only (answered "False"):

I believe that my home life is as pleasant as that of most people I know.
My conduct is largely controlled by the customs of those about me.
I wish I were not so shy.
What others think of me does not bother me.

Thus, in addition to the tendency to dwell upon somatic difficulties, such as headache, tremulousness, fainting, and an evasiveness about the sight of blood, the hysteric (as revealed by these items of the Minnesota scale) is remarkably concerned about social matters: he is friendly with one and all, he suspects nobody. He is naive and trusting, open and friendly, yet, like the psychopathic personality, he is concerned about how he is accepted socially.

Regarding the thematic apperception stories, Masserman and Balken (96) state that

> In conversion hysteria many of the phantasies, though characteristically superficial and at times flippant, tend to be rather frankly sexual in content and often involve persons more or less easily identified as members of the patient's immediate family; the erotic scene, however, usually ends in frustration. Hypochondriacal symptoms, where present, are often included in the phantasies, in which case they are projected, although in a somewhat disguised form, onto a martyred, misunderstood, long-suffering hero or heroine. (Page 86.)

The Rorschach of the hysterical patient is characterized by (*a*) repression broken through, particularly in the presence of color, and by (*b*) sudden outbursts of highly dramatic responses (such as sudden anatomical sexual responses, color shock). Hysterics are basically extratensive; they are sensitive and reactive to the environment, even though this may be revealed only by intense repression.

The following case of mild hysterical maladjustment, reported[2] by

[1] Also contributes toward score for masculinity-femininity.

[2] Reprinted by permission of Grune and Stratton, Inc., from *The Clinical Application of the Rorschach Test*, by Bochner and Halpern.

Bochner and Halpern (19), is presented with a brief synopsis of the history and the complete Rorschach record.

Case History: The subject is a twenty-eight year old white woman, single, college graduate, I.Q. between 115 and 120. She holds a professional position, works ably, and is well thought of by her superiors and colleagues. Her manner is pleasant and outgoing, she makes friends easily, and is often the "life of the party." She is an only child and has difficulty with her mother who is not her intellectual equal. There is constant conflict at home because she realizes she should break away from parental domination, and yet for emotional reasons is unwilling to do so. As she says, "How can I do this to them?" Occasionally she takes a definite stand, but only on an intellectual, never on an emotional level, and generally as the result of continual pressure from her friends. . . .

She has a boy friend with whom she has gone for many years, and whom she plans to marry as soon as his financial situation warrants. Recently their love-making went beyond the usual petting and ended in intercourse. In the six weeks which have elapsed since this episode the subject has not menstruated, and although such irregularity is not unusual for her, she is distraught by the fear of pregnancy. (Page 94.)

The Rorschach responses[1] were as follows:

I.*	4″ ∧	1. Butterfly.	Shape of it (whole).
32″		2. Lobster.	Just a lobster claw (pointing to small upper projections)—just its shape.
		3. Skeleton.	Drawing of a human figure (center detail).
		4. Triangles.	White spaces, their shape.
II.		Mm——.	
54″	9″ ∧	1. Dwarfs.	Shape and color (upper red).
		2. Blood (peculiar intonation).	All the red spots.
		3. Spinal column.	White hole (center) shape of it.
		4. Butterfly.	Down here, (lower red) shape and color.
III.	2″ ∧	1. Two men dancing.	Their shape (usual men).
39″		2. Death head up here.	Like the death head (usual men's heads) I have on my desk at home.

[1] *Ibid.*, pp. 84–85.

* The time given directly below the number of the figure is the time spent in looking at this blot. The times given together with the responses are times elapsed between presentation of the figure and the response. Material given in the right-hand column refers to the "inquiry" or second perusal of the figures, during which the patient explains his original responses or modifies them. The symbol ∧ indicates that the card is held upright.

		3.	Spinal column.	Shape of it (small white space in lower center grey).
IV. 48″	10″	Λ	Blackness is my main impression and heaviness sort of.	
	25″	1.	All stuff hanging over ledges, rocks.	Like when I was on my trip out West and I saw all the rocky peaks. The whole thing, it's solid looking.
V. 27″	1″	Λ 1.	Butterfly again.	Whole, the shape of it.
			Just blackness again, narrow like.	Sort of thins out on this more than on the others.
VI. 36″	12″	Λ 1.	Animal with a face up here on top.	Whole, see it has paws (points to lateral projections).
		2.	Something about this looks like the skin of a snake (laughs).	Lower part, scaly effect.
VII. 21″	5″	Λ 1.	Two women looking at one another, hair upswept.	Shape (upper third).
VIII. 52″	4″	Λ	As soon as I see this, I think of color.	
	19″	1.	Things on the side look like rats.	Shape (usual animals).
			Orange makes me think I had orange for breakfast.	
		2.	Butterfly.	Shape and color, more the color (lower orange and red).
IX. 44″	12″	Λ	Green strikes me because I haven't seen green before.	
	23″	1.	Pregnant woman.	Shape (lower bulging edge of orange).
X. 48″	4″	Λ 1.	Crabs.	Shape (usual).
			There's a scattering about this, more whiteness.	
		2.	Rabbit head.	Shape (usual).
		3.	The balls, testicles.	Shape (usual wishbone).

The authors summarize their interpretation of the Rorschach:

. . . from a study of the numerical results we may say: This is a woman of average or better than average intelligence who is subjecting her emotional life to rigid control. This control has resulted in a constriction

of her affective life, but in spite of this, some situations prove too strong for her, and the discipline gives way to impulsive, socially unacceptable behavior. Although she is basically of an outgoing nature she is shying away from external stimuli. Some situations are sufficiently potent to cause a definite change in her entire mode of attack, and their influence continues long after the circumstance has been left behind. Before this situation arises she follows an efficient plan, and shows an ability to go to the heart of a problem. There is an over-desire to conform that stifles originality. Some preoccupation with body parts . . . possibly on a hypochondriacal basis, is present. (Page 88.)

After blot-by-blot analysis, the authors add the following interpretation:

The shock of some dark, overwhelming threat . . . is so real for this subject, that she becomes completely disorganized when faced with it. The disturbance is obviously of sexual nature and from an analysis of the contents of her responses seems linked with question of pregnancy. She is attempting to minimize or avoid the implications of this by misinterpreting or denying the symbols of male genitalia. In view of her desire to conform, this suggests that there has been some deviation from the "beaten track." (Page 94.)

Unsuccessful Solutions to Anxiety That Are Personally Elaborated

We have used the example of *hysteria* to represent that pathological reduction of anxiety that is socially oriented and hence extratensive. We can now switch to the other extreme and consider *psychosis*. Psychosis is characterized objectively by such withdrawal from, or distortion of, the reality of the present environment that the individual is considered socially to be a liability to himself and others. Psychosis may emerge following damage to the nervous system—for example, hardening of the brain arteries (cerebral arteriosclerosis) or syphilis (paresis or general paralysis). Psychosis may emerge following extreme use of certain drugs, particularly alcohol. When definite tissue changes seem to precede or accompany the symptomatic psychological changes of psychosis, it is said to be *organic psychosis*. Most psychoses, however, have no demonstrable organic concomitants and are said therefore to be *functional psychoses*. In this respect the functional psychoses are like the psychoneuroses, since neither can be shown to be the result of actual damage to the nervous system. Of the functional psychoses the most fre-

quently encountered are, in order: *schizophrenia, manic-depressive psychosis, involutional melancholia,* and *paranoia.* As is true of the neuroses so the signs and symptoms of psychosis often blend together in such a way that differential diagnosis is difficult.

In clinical psychopathology diagnosis of psychotic conditions has been undertaken traditionally on the assumption that the clinician was himself cognizant of the reality of the present environment and that by evaluating the patient's *appropriateness*—emotionally and in his language and thinking—he could estimate also the extent to which the patient was cognizant of environmental reality (*i.e.*, the degree he was like the clinician, sane). In clinical practice it became customary to consider that certain characteristics of behavior—those most obviously bizarre—were pathognomic, *i.e.*, immediately diagnostic. Two of these characteristics were *hallucinations* and *delusions.* An illustration of traditional diagnostic procedure is presented in the case on pages 142–143, in which it was decided the patient was psychotic only after his delusional ideas had been uncovered. The term hallucination refers to a sensory experience that cannot be attributed to stimulation from the immediate outer reality: hearing voices, seeing images of persons or objects that are absent, etc. A delusion is an idea or belief which is based on an obviously wrong hypothesis and which cannot be corrected through logical argument. The patient who firmly believes he is Napoleon is deluded, just as is the pauper who not only believes he can write checks for a million dollars but writes them.

We see that in traditional practice the presence of hallucinations and delusions was considered indicative of psychosis. Other aspects of the patient's behavior were also considered diagnostic: emotional response (appropriateness of affect) and intelligibility (coherence, stream of talk, logic of thought, etc.).

The student can readily see that in such an approach the clinician's problem is almost entirely one of judging the extent to which the patient's behavior is queer. In this earlier approach, there was little attempt to take the opposite point of view, *viz.*, that the patient was, after all, a personality that developed or emerged essentially according to the dynamics of all personality development. To understand the patient, the clinician felt he had only to determine how insignificant reality was to him. He felt little need to know just what to the patient *was* significant. In recent years, particularly following Freud's early work, it became obvious that if he

were to understand and help the psychotic individual the clinician needed first of all to put himself in the patient's place, to adopt his reality no matter how peculiar it seemed. Let us assume that the patient is, as he says he is, Napoleon. Why should he be Napoleon? What frustration to his ego requires such inordinate gratification?

In the long-developed psychotic it is sometimes impossible to penetrate at all within the mysterious inner life, so that analysis of his reality often cannot be accomplished. Despite the clinician's most painstaking attempts to empathize, the patient's behavior defies interpretation and his verbalization remains a "word-hash" completely mystifying. We shall see, however, that in its psychogenesis the departure from reality in such a patient is not so much a withdrawal as it is the active elaboration of a *different* reality. The psychotic patient, were he interested, might very well consider the clinician crazy, for to the patient the reality of the clinician may be as mysterious and illogical as his own appears to the latter.

Schizophrenia

Let us consider, then, as the prototype of the reduction of anxiety through personal elaboration, the functional psychosis, *schizophrenia*. In our earlier discussion of psychogenesis, we saw that schizophrenia represents a reduction to anxiety, a reaction of frustration by means of fantasy. Fantasy to the normal child is an important source of gratification of the basic needs of ego recognition and love, and our society does much to foster it. In the child's dreams his problems are solved; he achieves wealth and fame, he earns the hand of the beautiful princess and carries her off on his snow-white charger. The world of washing and going to bed early, of teacher and arithmetic is, for the nonce, eliminated.

As the child grows his daydreaming acquires an increasingly individualized pattern. He may read avidly of Dick Tracy and Terry and the Pirates, transporting himself thus to far lands, facing dangers without flinching, serving the causes of justice and honor. His ability to identify himself with these heroes and later, in adolescence, with the screen lover satisfies needs not otherwise fulfilled.

Another child may find in an old tin can or a discarded motor as much satisfaction as he does in the most expensive toy. A love of tinkering with gadgets, an interest in radio or in model airplanes may later emerge as a really constructive trend. Radio and air-

planes have about them qualities of the mystical, of ethereal flight and transcendant movement and power. A stamp collection carries the mind to all parts of the world.

In childhood, interests such as these are highly desirable and certainly to be encouraged. They become of concern only when they occur in isolation and when in their function as fulfillment of need they too greatly replace social satisfactions.

The child who can entertain himself and keep out of the way is often considered good. In his daydreams, hobbies, and collections the child outwardly seems content. His solitude is not at all despondent. Apparently, in fact, it is of his own choosing. The external impression of contentment often suggests that the child's needs are adequately satisfied.

Certainly the greatest creative achievements of man have emerged from within the secret recesses of the personality, for they are the materialization essentially of dreams. But great contributions differ from idle fantasy in that they transpose socially so that they are constructive. When the inner elaboration is developed irrespective of ultimate social expression, we detect the schizoid trend. It would be accurate to say perhaps that much of the child's life before adolescence is spent in schizoid activity, *i.e.*, in activity that is fantastic and personalized, elaborative and imaginative. We do not expect the child's dreams to materialize socially, nor do we feel that his elaborations because they are unproductive are necessarily wasteful. It is in later life, when we expect the individual to participate actively in socialized forms of adjustment, that his failure to do this because of schizoid preoccupation is to be considered pathological and, in extremity, psychotic.[1]

The older name for schizophrenia was *dementia praecox*, meaning "insanity of youth." Although isolated cases of schizophrenia have been reported in children prior to adolescence,[2] it is nevertheless true that this disease usually is first detected in adolescence or early maturity and rarely much later. For this reason it might be supposed that schizophrenia is a solution to some conflict of adolescence.

[1] The subjective picture of childhood schizophrenia is well revealed in the story "Silent Snow, Secret Snow," by Conrad Aiken (2).

Willa Cather has portrayed very beautifully the schizophrenic in adolescence in "Paul's Case" (26).

[2] Two excellent discussions of childhood schizophrenia are to be found in Bradley's book (20), and the issue of the journal, *The Nervous Child*, Spring, 1942.

This is true but only in a very special sense. Schizophrenia occurs in all cases as the ultimate expression of personalized elaboration begun in early childhood, long before puberty. Thus, schizophrenia following puberty is always preceded by a schizoid trend in preadolescence. This does not mean that the life of fantasy in the normal child is an early indicator of schizophrenia, for we have seen that all children indulge in fantasy and we know that very few develop psychosis. The important thing in this connection is to realize that the psychogenesis of schizophrenia and of daydreaming are identical; the psychosis is simply an exaggeration of tendencies that in normal childhood are precursor to the normal individuality of the personality.

Schizophrenia has been studied from many points of view. Psychological studies of peculiarities of language and thought and of the appropriateness of emotional response—all agree that an outstanding characteristic is that there are very great differences between schizophrenics. This is quite to be expected when we realize that fundamental to schizophrenia is *individuality* or "differentness."

Despite this fundamental diversity among schizophrenics the student will encounter classifications of schizophrenia, at least under four major headings. First, *simple schizophrenia,* which is characterized by adjustment that seems unrelated to usual social standards. Many tramps, prostitutes, and social dependents are probably to be considered in this sense schizophrenic. Their lives are uncomplicated by usual standards of living; they seem to lack motivation, but in truth their motivation is simply different. It is less ostentatious. Often misinterpreted as mentally deficient, the simple schizophrenic is found on closer examination not so much to be lacking in capacity as to disregard those forms of behavior that we ordinarily consider to be intelligently adaptive. Hence he appears detached from the usual environment.

In *hebephrenic schizophrenia,* or *hebephrenia,* we find queerness—in speech and manner, in unusual silliness or other emotional inappropriateness, in motivation that seems pointless. It is in the hebephrenic that *elaboration of personal reality* is most clearly revealed. Hebephrenia differs markedly from *catatonic schizophrenia* or *catatonia,* a syndrome in which the nature of the personal elaboration is probably least apparent but in which the *withdrawal* feature is most prominent. In the stupor of catatonia the patient is so absorbed in his own inner life that the outer environment often seems to have

no significance for him whatever. He may sit motionless for hours, apparently insensitive to stimulation. That such an individual is not truly insensitive, however, is shown by the fact that his startle response is normal or even exaggerated (86), possibly because the suddenness of stimulation is intensified by the greater disparity between the environment and the focus of attention.

A fourth type of schizophrenia—one in which delusions particularly of persecution are predominant—is *paranoid schizophrenia.* The paranoid patient is usually brighter than other schizophrenics—at least his intellectual capacity is relatively obvious. The paranoid trend seems to be a projection of hate toward others (particularly of the same sex) as if to ward off love and is found often to involve conflicts over homosexuality. We shall discuss paranoia in more detail in the next chapter.

An important problem for consideration in all personal elaborations but particularly in schizophrenia is the focal significance of sexual conflicts. In schizophrenic thinking sexual symbols and associations are often prominent, while in the patient's behavior masturbation is frequently observed. Important in this connection is a fact mentioned above, that the obvious manifestation of the disease usually occurs in adolescence. As we have seen earlier, masturbation often in infancy and usually in adolescence is accompanied by fantasy. Masturbation is the erotic focus on the self. We can therefore consider masturbation to be a personal elaboration that is erotic as compared with those elaborations in fantasy that are manifestly more intellectual. Often the schizophrenic is preoccupied with inanimate forces within himself. In extreme schizophrenia we frequently find certain preoccupations with bodily functions, particularly eating and elimination—functions that we have associated with infantile sexuality. The frequent obscenity of the schizophrenic's speech and his frequent lack of personal care clearly demonstrate this. The extreme schizophrenic is essentially narcissistic. Eroticism need be not at all prominent, but when it is present it is frequently characterized by masturbatory phenomena.

One often finds in schizophrenia an inordinate preoccupation with religion. As we have seen earlier, religion affords to many normal individuals an outlet for the sublimation of basic impulses for expression. It is clear that where feelings of guilt are salient features of the personal conflict, as is the case in severe psychosis, the consolation of religion is often important. Furthermore, it is

understandable that concepts such as the omnipotence or omniscience of God may be readily distorted, so that to the schizoid individual they afford a means of projecting the responsibility for his own behavior onto some force that is admittedly beyond his control. The schizoid individual seems often to find in the intellectual aspects of religion a partly elaborated logic for his preoccupation with basic life forces. Moreover, the rich symbolism of religion permits distortion in schizophrenic thinking, in that morbid and sexual values may easily be represented by religious concepts.

The following letter[1] written by a schizophrenic woman to one of the physicians in her hospital and presented by Noyes (104) illustrates the manner in which loosely organized themes centering around sex, personal grandeur, and persecution are elaborated autistically and yet with an approximation of meaning nevertheless.

Dear Dr._____

"My Plan," or as mother used to call you, "The Little Plant," or else one little Plant for I was the other Plant, called "Tant." Will you please see that I am taken out of this hospital and returned to the equity court so I can prove to the court who I am and thereby help establish my identity to the world. Possible you do not remember or care to remember that you married me May 21, 1882, while you were in England and that I made you by that marriage the Prince of Wales, as I was born Albert Edward, Prince of Wales. I am feminine absolutely, not a double person nor a hermaphrodite, so please know I am England's feminine king—the king who is a king.

Your first duty is to me, and if you do not intend to do the right thing, helping me to get out of here, stop the thefts of clothing, money, jewelry, papers, letters, etc., etc.; you will please let me know so I can make some absolute change and further demand of the nations my release.

1874 Building was to have been a palace for my mother, father, myself and you, that is, if you are the one I married—so why not get busy and furnish it up as such when I go abroad. Make my trips (our trips?) short and return to America on important matters and have the right place to hold court. You and Dr. Black can take me to the equity court where I prove up my individuality and this must be done.

Sincerely,
"Tant"

Queen of Scotland, Empress of the World, Empress of China, Empress of Russia, Queen of Denmark, Empress of India, Maharajahess of Durban, "Papal authority" as a Protestant. (Page 445.)

[1] Reprinted by permission of W. B. Saunders Company.

Performances of Schizophrenics

In an effort to find signs of diagnostic significance, considerable interest has been shown in the differential test results of various categories of psychopathology. One of the most consistent findings in the test performances of schizophrenics in particular is that these patients are heterogeneous. So far as many performances are concerned, schizophrenics differ as greatly among themselves as they do from normals—further evidence that schizophrenia is characterized overtly by primary individuality or "differentness."

A second consistent finding in the test performances of schizophrenics is unevenness of response. On tests the individual patient is likely to give poor responses side by side with responses that qualitatively are amazingly good. This is an effect of the specialization in areas of experience and learning and the varying motivation and interest in the different tasks, more than it is a reflection of the often-held belief that the schizophrenic is deficient in certain kinds of abilities. Psychological test performances require thinking and expression that are logical from the examiner's point of view, and it is natural therefore that, as we shall see, the schizophrenic's peculiar logic often distorts his responses in such a way as to render them apparently senseless.

Careful studies, particularly those of Vigotsky (141), of Goldstein (47), and of Hanfmann and Kasanin (57), reveal that in their relative incapacity to deal with abstract concepts at least some schizophrenics are like cases of actual brain damage. It was found in tests requiring the patient to find some general principle of classification that both organics and schizophrenics had difficulty. However, whereas the organic patient was simply perplexed and unable to find any solution whatever, the schizophrenic tended to find solutions, but wrong ones—personalized solutions that were based on wrong premises. The schizophrenic might limit himself to the blocks that formed the test material of the Vigotsky, but he might also include the desk and blotter on which they rested, or even the examiner as objects to be classified with the blocks (24). Such performance has been considered a deficiency in categorical behavior, the ability to handle abstractions. It may be considered just as rightly a tendency for the schizophrenic to abstract either wrongly or so personally that the logical solution is achieved only with difficulty.

In a study of schizophrenic patients (and also patients with

organic pathology), Hanfmann (55, 56) found that their performance with the Healy Pictorial Completion Test II was frequently characterized by peculiar placements of objects within the pictures (56):

Sometimes the patient completed only the represented action, without any regard for the rest of the situation. Thus, in the picture representing children in the fields who are looking up at something, the subject may place in the portion of the picture representing the sky, a man, an automobile, or a dog, commenting simply: "Those boys are looking up at a dog." Or he may go even farther in his disregard of the physical reality and not refer at all to the outward action represented in the picture, such as looking at, or pointing to an object. Instead, he bases his placement on psychological moments, such as the thoughts, needs and wishes of the person represented. The picture of a tie, for instance, is placed on the horizon with the comment: "The boy needs a tie for his collar," or a horse is in the room because "the boy wants a horse—he wants to become a traveller." Finally, even the specific connection of wishing or thinking, obtaining between the person and the object, may be dissolved in favor of a more indefinite impression that a certain object belongs within the sphere of the represented situation or activity. Thus, a milk bottle may be placed on the wall because "people are having breakfast."

Occasionally the patient's wishes or fears influence the completion. One patient, for instance, decides against using the block with the picture of spilt ink, because, as he says, he himself would not want to drop the ink. Or he may protest that he is not the one who smashed the face of the boy in the picture. The picture, in such cases, seems to be given the status of reality.

Completions colored with personal reference were more common in the schizophrenic than in the organic group. The same was true of another kind of peculiar completions, which might be described as symbolic summaries of the pictured situations. The object inserted does not belong to the same concrete sphere of action as other objects in the picture: rather, it summarizes the pictured scene, giving its meaning, or its keynote. Thus, pictures of books are used as providing a key to school scenes: "The book is up—that means the boy is going to school"; a broken flower pot is inserted into the picture representing an accident, because "the boy's head—his mind—is broken, as is the flower pot"; clocks are made to stand for the events that usually fall into a definite time of the day: "six thirty—time to go to supper." (Pages 230–231.)

The intra-individual variability that many schizophrenics show on tests of capacity such as the Wechsler or the Stanford-Binet early suggested that disparity or scatter might be used as an index of the disease. Wechsler, for example, showed that for his battery of tests

schizophrenics tended to do relatively well on Information and Vocabulary and to do poorly on Arithmetic, Similarities, and the Digit Symbol tests. It is apparent that the first two tests involve earlier learned material, while the latter three involve problem solving and the handling of abstract concepts. The tests of Babcock (6) and Shipley (128) are constructed primarily to yield a ratio of the abstract capacities to the earlier learned capacities as exemplified by vocabulary; for cases of brain damage we have seen that these are often valid. Among schizophrenics, however, there is often poor performance on all tests so that no scatter or variance is shown; sometimes the schizophrenic simply does not perform well on anything.

Although performance discrepancy may be suggestive of organic deterioration, it is the opinion of the author that discrepancy cannot be considered evidence of schizophrenic deterioration for the following reasons: first, differences between schizophrenics in the nature of the *pattern* of scatter suggest again that the intra-individual disparities are reflections of the unique experience and learning of the individual patient—of the patient's lopsidedness—rather than a loss of capacities common in all schizophrenics; secondly, rapport and sustained effort of schizophrenics vary with the task. Tasks in which the patient can readily be induced to participate yield better results than those that have little attraction for him. Thus, the overt performance of the schizophrenic is a function only secondarily of capacity; it is a reflection primarily of the degree to which he can be motivated or, in other terms, of the degree of control that is exercised in his approach to the task. This point has been well summarized by Hunt and Cofer (69):[1]

> The deficit in the "functional" psychoses, and particularly in schizophrenia, we conceive as an extinction of standards for performance and of thought skills that have been socially rewarded. The deficit in these disorders is also complicated by conflicts between response tendencies and by distraction from idiosyncratic preoccupations which arise as substitutes for the socially rewarded skills and responses.

To consider that the schizophrenic's mental test performance is a measure of capacity is, according to this point of view, an illusion.

The performance of the patient on psychological tests provides, of course, a rich source of qualitative material often suggestive of

[1] Reprinted with permission of The Ronald Press Company, from *Personality and the Behavior Disorders*, J. McV. Hunt (ed.).

disordered thinking. Answers that are queer or irrelevant or that reveal high personal valence for the particular question or neologisms or unusual word combinations are of immediate interest clinically because they suggest schizophrenia. We have seen that on nonverbal tests that involve the capacity to generalize, such as the Vigotsky, schizophrenics often fail. They fail also on sorting tests and on tests such as the Healy completion.

A careful analysis of the behavior of disorganized schizophrenics in test situations leads Cameron (24)[1] to characterize their talk as

> . . . (1) *asyndetic, i.e.*, lacking in essential connectives; (2) *metonymic, i.e.*, lacking in precise definitive terms for which approximate but related terms or phrases are substituted (many of these being personal idioms); and (3) *interpenetrative, i.e.*, having parts of one theme appearing as intrusive fragments in another unrelated theme. . . . Their problem solving in a grouping test brought out in both talk and manipulation (4) *overinclusion, i.e.*, environmental and imaginal material often only remotely related not being eliminated from the problem; (5) frequent *noncorrespondence* between what the schizophrenics did and what they said about that which they had done; (6) the calling for *transformations* in the rules of procedure and in the materials to justify failures; and (7) varied and shifting verbal *generalizations* concerning solution hypotheses which were, however, usually inadequate. (Page 891.)

Schizophrenia as Revealed by the Minnesota Inventory. Seventy-eight of the Minnesota items contribute toward a score for *schizophrenia;* of these, 48 or 72 per cent overlap with other variables. The items that contribute *only* toward *schizophrenia* (or masculinity-femininity) are as follows:

Answered "True"

There is something wrong with my mind.
I cannot keep my mind on one thing.
Peculiar odors come to me at times.
Sometimes my voice leaves me or changes even though I have no cold.
I have never been paralyzed or had any unusual weakness of my muscles.
The things that some of my family have done have frightened me.
Once in a while I feel hate toward members of my family whom I usually love.[2]
I have never been in love with anyone.
Many of my dreams are about sex matters.
I wish I were not bothered by thoughts about sex.[2]

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[2] Scores also for masculinity-feminity.

I dislike having people about me.
I refuse to play some games because I am not good at them.
Most anytime I would rather sit and daydream than to do anything else.
I am so touchy on some subjects that I cannot talk about them.
Most of the time I wish I were dead.
Everything tastes the same.
I often feel as if things were not real.
I hear strange things when I am alone.
I am afraid of using a knife or anything sharp or pointed.
Sometimes I enjoy hurting persons I love.
At times I have enjoyed being hurt by someone I loved.

Answered "False"

My hands have not become clumsy or awkward.[1]
I loved my mother.
My mother was a good woman.
I loved my father.
My father was a good man.
I worry over money and business.
I enjoy children.
I seem to make friends about as quickly as others do.
I get all the sympathy I should.

Four items contribute toward scores for both *schizophrenia* and *psychopathic deviate* only:

Answered "True"

During one period when I was a youngster I engaged in petty thievery.
I have had very peculiar and strange experiences.

Answered "False"

My sex life is satisfactory.
I have never been in trouble because of my sex behavior.

On only two items does *schizophrenia* overlap only with *hysteria.* such that a score for each is derived therefrom:

Answered "True"

Once a week or oftener I suddenly feel hot all over, without apparent cause.
I am worried about sex matters.[1]

We see from these answers that the schizophrenic is concerned about himself. While his social acceptance is a problem—in that he hesitates to become conspicuous socially or to take an attitude of open friendliness toward the opposite sex or toward children or even toward parents—his real concern socially is in regard to his

[1] Scores also for masculinity-femininity.

own acceptability. He is preoccupied about his mind, about strange odors, about experiences that he has when alone. Like the hysteric, sex matters worry him. Like the psychopathic personality, his actual sexual adjustment is a problem.

Schizophrenia as Revealed by Projective Techniques. We have seen that the schizophrenic's performance with a task such as the Healy completion pictures not only may reveal his disordered thinking but may further suggest the nature of his peculiar logic. In the graphic art of schizophrenics, in their literary and even verbal productions, autistic basic premises and trends of thought often are dramatically portrayed. In many cases, however, productions are so bizarre as to defy all attempts at interpretation.

In the stories produced in response to the thematic apperception pictures, schizophrenic phenomena appear, according to Masserman and Balken (96), in these ways:

> In certain cases there is an apparent inability to construct abstractions or to go beyond an impersonal, concrete, literal description of the picture (the Vigotsky phenomenon). In other cases—which again do not correspond with any clinical sub-type of schizophrenia—the phantasies are disjointed and highly bizarre, and have either little connection to the picture or no apparent relationship with it at all. Finally, in later stages of the schizophrenic process, evidence of disintegration appears in the form of "blockings," uncompleted sentences, bizarreness, perseveration of ideas, etc. (Page 87.)

Balken (7) reproduces the first and the third stories told by one schizophrenic, a comparison that portrays an amazing quality change. In response to the first picture (the boy with the violin):

> He looks just the way I feel—that's all the sensation I get out of the picture. Of course, if I look at the violin, I can see more in it and if I want to go on studying the picture reminds me of a little girl about, I guess, she's about seven years of age. This is a little girl whom I knew—she had been coaxing to take violin lessons at school. She would get the lessons, but she had no fiddle—no violin. An old friend from out of town when he was visiting the family learned of her desire and told her that he had a good fiddle that no one used and which she could have. He said he would give it to her when she went to visit his home—his home town—they were neighbors. Now I have to stop and think it over in order to make. The next morning after she arrived she got up at six o'clock to awaken the neighbors to get her fiddle. That's all the picture would flash in my mind. (Page 245.)

The patient's story for the third picture:

Well, it could suggest war and more sharp featured live ghosts on Flanders Field reminding us that the dead shall not have died in vain. The world war veterans—who gave their lives—though in recent years it has seemed futile—did not give their lives in vain because they taught us that it is futile and senseless for America to enter the war. (Correcting the examiner)—That should read "be" instead of "is." (Page 246.)

Schizophrenia as Revealed by the Rorschach. As with other test materials, schizophrenics react variably to the Rorschach. As Klopfer and Kelley (81) state emphatically, there is "no single definite Rorschach or personality picture typical of schizophrenia as a whole." Based on a number of studies of Beck (13), Rickers-Ovsiankina (115) and others, summarized by Klopfer and Kelley (81), a variety of signs has been proposed that more or less suggest schizophrenic tendencies and occurring together might be considered diagnostic. These signs must be understood in the light of reflections of individuality in the personality rather than as objective indices diagnostic of pathology. We have attempted to summarize the various findings as follows:

The lesser significance to the schizophrenic of outer reality is revealed in tendencies

1. To nonparticipation, as revealed in an attitude of disinterest, in rejection of any or several cards, even those infrequently rejected by normal individuals, in lesser production quantitatively, a lack of qualification of forms seen, and a tendency to use weak whole responses.
2. To give few popular, frequently seen responses.
3. For form to be qualitatively poor.
4. To ignore frequently used details.
5. To use color directly rather than in combination with form, *i.e.*, the concrete environmental potential that is contrasting rather than subtle.

Personal elaboration is seen in tendencies to be preoccupied with unusual details. Similarly, the schizophrenic tends

6. To give unusual original responses, even though often of poor quality.
7. To perseverate and thus reveal a personalized thematic pervasiveness that is peculiar to the individual and relatively unaffected by the changing nature of the blots.

Failure to achieve integration of environmental potentials and personalized elaborations is revealed in tendencies

8. To give contaminations, *i.e.*, to utilize concrete aspects of the blots in such a way as to form a new concept, as in the example given by Klopfer and Kelley, the green figure resembling a bear being considered as "grass bear."

9. Toward confabulation, *i.e.*, whole or large detail responses because a small part detail suggests some part of the figure. Thus, a detail may indeed look to most people like the foot of a man. To the schizophrenic the whole card may then be "man," even though to normals the whole has little resemblance to a man.

10. To give positional responses. Similar to confabulations, these responses are characterized by the patient's seeing a head in the top detail of the card simply because it is at the top, just as he might in a lateral detail see an arm.

11. To infrequent use of movement. The projections of the schizophrenic lack the creative integration represented by movement.

One point that requires further consideration is the finding that the schizophrenic, whom we have considered to be the prototype of introversion, uses movement little and color in a much less inhibited way than do normals. This single Rorschach finding suggests that the schizophrenic might be considered extratensive rather than introvertive. However, both in the decreased movement and in the tendency to give pure-color or color-form responses rather than form-color the schizophrenic reveals his failure in constructiveness rather than a heightened sensitivity to environmental potentials. Just as the startle response is heightened in the catatonic (86), probably because of the great specificity of the stimulus and its greater contrast to the inner reality, so the crude color seems to stand out to the schizophrenic as something more concrete and dramatic; to the normal individual, color is simply one of the attributes of the ink blots that may be used integrally with other properties such as form in meaningful expression.

The fact that the schizophrenic uses movement no more than normals do is evidence, as Beck (13) says, "that schizophrenics as a group do not engage in more fantasy activity than a group of nonschizophrenics. . . . " Emphasizing their poor use of form and their infrequent projection of movement, Beck concludes that "the schizophrenic excels in his tendency to misconstrue the world that is presented, giving it a form and outline which the healthier do

not see, rather than in a greater creative power or in a superior ability to transmute his experience into something new and richer."

The schizophrenic projects himself into the ink-blot material, but he does so not by means of movement so much as by identifying the qualities of the blots with his personally elaborated reality.

The following case of schizophrenia, taken from Beck (13),[1] presents, after a brief history, the Rorschach responses and Beck's summarized interpretation of the record as a whole.

The patient, P, was twenty-three, a college graduate, and had . . . studied music. She was an only child. . . .

P's admission to the hospital followed bizarre behavior manifestations, including the feeling that she was being hypnotized, that she was receiving telepathic messages from a lover in a distant state, and that she was a "mental" case. An apparent suicidal attempt—she cut her wrists—precipitated her referral for psychiatric observation. The physician attending her at the Psychopathic Hospital noted the emotional turmoil, probably complex determined, on the background of which the symptoms appeared. Citing from the clinical record, "Much of the distortion is in the form of telepathic messages from a lover and seems to be of a frank, wish-fulfilling nature. More ominous than that are the feelings of bodily influence and change, as well as beginning feelings of estrangement. The suggested diagnosis is schizophrenia, paranoid type, but the examiner is of the opinion that the whole process is less malignant than the diagnostic label would imply. There is a history of previous mental illness, requiring a comparatively brief stay in a sanitarium. Sexual promiscuity began at about the age of 18; previously, some homosexuality. Occupational history shows uneven trends; jobs varied from selling to teaching, meanwhile qualifying as a flier. . . . From the Psychopathic Hospital she was committed to another with a final diagnosis of "dementia praecox, paranoid," "condition unimproved." (Pages 18–19.)

Following are the Rorschach responses:

I.	1.	Well I don't know it looks like a scarab (middle).
	2.	Or what do you call it? An arabesque (W; especially because of the dot in the center; and it is like a similar design that patient once made).
	3.	Or a condor (the lateral detail reminded patient of a Condor Mountain where she had once been).
	4.	It has a central white dot . . . oh yes, it looks like a Hallowe'en lamp, grinning, a demon of sorts (only because the white space reminded her of eyes and teeth).

[1] Reprinted with permission of Nervous and Mental Diseases Publishing Company.

5. An hour-glass in the center (the lower half of middle).
6. I am very sorry to say, to admit it, this lower thing here is phallic, it looks like a penis (lowermost projecting detail of middle).
7. And I don't know what it is up there. It looks like . . . (patient is in obvious struggle), it looks like the balls of a man (upper center oval details).
8. And this looks like a woman's body (interior middle portion).
9. And that looks like a lobster up here (the two upper claws) . . . but it should remind me of something else.

This is the most cleansing thing that's happened to my mind in a long time.

II. 10. V∧V The same sort of thing up here, the devil or unicorn on top (the lower butterfly section; later sees it as a steer; it has horns, it is symmetrical and has long thin eyes).

11. A lady's legs in a bathtub (the lighter gray in the upper middle pointed detail).
12. This is lower zones . . . phallic (middle pointed detail).
13. And these are . . . (blushes) I'm getting modest (tears) it looks like a scene . . . the atmosphere of a scene in a book . . . by James Branch Cabell called "Jurgen" . . . and the scene was with the woman . . . and her name begins with an A and it is about our bodies being made for pleasure (the entire, the gray and the red and the white "I think in terms of color often").
14. It looks like thumbs (upper red portions).
15. It looks like cloud formations (lateral black portion).
16. These are pretty smart-alec kings. They are King Lears (corner, lower).

I'm getting weaker, I'm not through.

III. 17. Two bodies here who are pulling away from each other or are drawn to each other, I don't know.

Ah! me, ah! me, that I the judge's bride might be.

18. It looks like plain seaweed (upper red details).
19. This looks to me like the idea of what a womb looks like or uterus . . . or something. . . . I don't know I never studied biology. I mean ovaries (lower middle black with intervening gray).

These people both have that King Lear expression.

20. And their necks look like . . . penises . . . in other words the center of it is sex.

IV. The same sort of thing . . . I'm getting tired of these (pleasantly).

21. A leg here and here, the legs of a woman (uppermost third of middle portion).
22. V Two figures, horns and the devil up top (lowermost portion of middle figure).

Something through here (and strokes entire middle with her finger).

Do you want me to try hard? (I knew that my problem was always being highly sexed).

23. Two figures again . . . or one figure (the lower darker portions in lateral).

They're hooded and in costume and I wouldn't care to meet them on a dark night.

24. And this is sort of like burning flame again going up the middle (the middle portion is a general shadowy effect).

25. A couple of cute people here with teacups (the small details extending from the lateral inwardly to the middle including the portion that resembles a horse's hoof when the test card is in the original position).

(Later P said, "And these are symbols. It reminds me of a royal scroll, looks like a symbol of some society.")

V. 26. That's a bat and it reminds me of stories of a vampire or what's his name who writes in the Saturday Evening Post? . . . Well it's symmetrical again . . . The same sort of thing, it's balanced, it has the same atmosphere.

27. And it looks like a scarab again (because of the atmosphere, *i.e.*, bat = vampire = mysterious = Egypt = scarab).

28. This here is something I have seen somewhere. It resembles another form of penis . . . I don't know (darker portion within head).

29. This also reminds me of something phallic (the white space between the lower tails) . . . It looks like shells on a beach and it is symbolical of fertility (because it resembles the vagina passage) . . . it is like a screw (and indicates a turning motion with her own hands).

VI. I'm curious now to know if these are exactly symmetrical (takes out her handkerchief and measures each side), the same sort of thing again, symmetry, balance, form.

30. Possibly . . . testicles (lowermost oval forms) . . . or labia (the adjacent projections strokes rapidly over middle black portion) . . . they all have sexual significance to me (later middle black portion reminded her of a wand).

VII. 31. These look like two men or old women having an argument (upper sections only).

This is symmetrical again.

32. It looks also like clouds (middle sections) . . . and I always enjoy reading faces in clouds.

33. And this looks like two suction caps stuck together such as you stick on windows (lower clasp).

34. These resemble goblins you read about (middle sections). I don't know, I stretched my imagination on it, I really don't know.
These resemble feathered plumes that dowagers wear (upper projections).

VIII. 35. Bears (lateral details).
36. My, it looks like some sort of astrological symbol. I don't know much about astrology (the bears = constellation, hence astrology; "and I was born under Aquarius"). Symmetry again.
37. This resembles a crown here (both middle blue as one) and this white thing in the middle I can't make out (later calls it a steer's head).
38. Looks like a spider (middle white space).
39. A scarab (the same).
40. And this again is sexual, female (lower most middle pinkish portion separating the orange details; "because it is an opening").
Or this is too at the top.
41. $\wedge < \wedge$ I don't know what this top thing is here . . . it looks like the grand Panjamum with a button on top (upper gray detail).

IX. It's symmetry . . . I'm getting weak now—I don't see very much. This isn't entirely symmetrical . . . it comes down on the sides . . . I don't know . . . a pattern here. I don't think it's entirely symmetrical, I'm not sure any of them were now . . . but I made my statement.
42. A couple of . . . either clowns or . . . (they have peaked hats; they have batons as if leading a band, and P acts out).
43. If I tried hard enough I could see eyes and nose and mouth . . . and a devil's sort of a head (the upper branch-like projections are horns; small white spaces within the green are eyes; the space between the green and lower pink form the mouth and the adjoining clawlike details could be fingers clutching something).
44. A burning flame in the center (middle stalk).
45. And this is candle grease dripping (lower purple portion only of stalk).
They're pretty colors.
(And it is a phallic symbol; a burning flame can represent either sex or salvation).

X. 46. Spiders, here (lateral blue).
47. Crabs here (lower lateral gray).

48. V Sort of angels of the Lord here (rabbit's head detail in lower middle), and on the other hand it could be a child with legs dangling.

49. Two pretty ghosts in blue, they're hanging on to a cliff (they're guardians and to get into the orthodox heaven they would have to get by these).

50. And this is some sort of symbol of 3 . . . of 3. O yes, of course, the Trinity, more or less symbolical of salvation . . . in fact it reminds me of Dante's Inferno . . . which I never read and ought to; I'm not a believer in the Trinity (triple-balled detail in the middle).

51. This is just a plain deep pit at the bottom without much chance of getting out (the large pink masses are forces outside working above and beyond an orthodox religion and this is orthodox religion being symbolized; P was not reacting to the white space.
"It is as though falling"; *i.e.*, it is an abstract symbol). You have symmetry here too and,

52. Two golden suns (inner yellow details); it looks like the Father, Son and Holy Ghost. I could call the gentleman up at the top Jehovah (rabbit's head detail). (Pages 19–25.)

After scoring and analyzing the record, Beck came to the following conclusions:

Intellectual processes: excess of attention to the minute; disorderly and inferior method; inaccuracy; inner balance: primitive and unstable affectivity, inadequate affective rapport with the environment, rich inner creative world. Balance of psychological processes: inner creative activity more than counterbalances total affectivity, hence the likelihood of inward turning of patient's conflicts; form accuracy too low for creativity, hence probability that patient disregards real world; affect too much for conscious intellectual control, hence the inaccuracy; discrepancy between much creativity, much affect, and low accuracy, on the one hand with, on the other hand, moderate organizing of material into meaningful relationship, an imbalance which throws additional light on the disease process. Stereotypy points to deviation of mental content which is ominous because on a background of mental disease, but conformity is still high enough to be a hopeful sign. Patient is highly resistive and the interpretation, in view of the whole personality would be that the resistiveness is a negativism directed against her own innermost wishes. The associational content is heavily saturated with sex and religion, includes examples of symbolization and of what appear to be condensed associations, and in its vocabulary and literary reference provides evidence that patient is of very good intellectual endowment. (Pages 65–67.)

CHAPTER XII

APPRAISAL OF CONTROL—III. THE SERIES OF INADEQUATE SOLUTIONS FROM THE SOCIALLY ORIENTED TO THE PERSONALLY ELABORATED

The two syndromes, hysteria and schizophrenia, stand at the opposite poles of a continuum—a single variable of progression from extratension to introversion: the hysteric solution to anxiety is socially oriented while the schizophrenic solution is personally elaborated. This chapter is devoted to the consideration of the various reaction types that lie along this continuum between hysteria and schizophrenia. But preliminary to this discussion, it is well to point out certain aspects of the continuum—certain contrasts between hysteria and schizophrenia that are its correlates and reflections.

On the surface, it may be stated generally that the hysteric solutions, in contrast to schizophrenia, are characterized by (*a*) somatic symptoms as focal to the personality and (*b*) conflicts concerning frustrations that are recent and of heterosexual nature. Schizophrenic solutions, on the other hand, are (*a*) focalized in inner elaborations in which somatic symptomatology, if present at all, is incidental and which are (*b*) eventuations of conflicts older and therefore usually predating the satisfactory establishment of heterosexuality.

We have seen psychologically that, in the female, sexuality is a pervasive experience and expression of the whole personality, one in which diffuse sensitivity is vital and to which the localized genital expression in orgasm is secondary. The female role is passive. In the woman, in her intense awareness of the menstrual cycle, of her function in pregnancy and in nursing, the significance of sexual physiology is continually reinforced psychologically. The girl's most dramatic experience at puberty is that of menstruation, a function clearly related to childbearing and heterosexuality. Menstruation to the young girl is an experience endured passively and totally: it is hardly a voluntary expression of the self. This is a

reinforcement to the girl of the total physiological nature of sexuality. The premium that the girl places, consciously or unconsciously, on anatomy and physiology is revealed in her emphasis on physical attractiveness, facial make-up, and dress and in her tendency to emphasize her figure advantageously.

The conflicts that typically render the woman anxious are those associated with heterosexual frustration, and their neurotic solution is typically in the form of somatic expression, *i.e.*, hysterical.

In the male (in contrast to the female) the psychological focus is toward ego assertion rather than toward social acceptance. This is expressed sexually in the urge to orgasm. The male role is active. In the life history, psychological reinforcement of this masculine focus on orgasm occurs in the pubertal experience of sexual dreams accompanied by seminal emission and of sexual fantasy with conscious masturbation. In the boy, the most dramatic change at puberty is the awareness of orgasm, a sudden new experience of intense erotic pleasure, an experience quite unlike the girl's first experience of menstruation. The orgasm is an experience that, the boy soon learns, can be induced by masturbation, and he learns soon also that this is an experience in which other boys are intensely interested. Thus, accompanied as it is by erotic fantasy, the orgasm serves as an elaborative, ideational focus on an erotic outlet that is aggressive, not passive. In these early boyhood experiences the degree to which motivation is heterosexual is secondary and often vague; certainly the direction of sexual orientation is incidental. The clear identification of self-assertion with heterosexuality develops slowly in the boy as the final culmination of a period during which he has usually experienced narcissistic and homosexual urges if not gratifications.

Thus, the conflicts that typically render the man anxious are not necessarily those associated with heterosexual frustration as they are in the case of the woman. Although the man's conflicts are sometimes aroused in situations of heterosexual frustration, they are often nevertheless related to earlier doubts, about masturbation or homosexual urges or guilt for the sin of self-indulgence. It is understandable then that in masculine psychopathology the involvement of fantasy and religious atonement for sin is often apparent, while the female emphasis on total physiological function and symptoms seems to play a secondary role.

It seems that women may develop schizophrenic solutions to

anxiety, while men may develop the hysterical. When these occur, however, they are usually reversals. The schizophrenic woman reacts malewise, while the hysterical man, though he is frustrated heterosexually, is feminine in his reaction to the anxiety thus aroused.

Rosanoff (120) prefers to designate schizophrenia as "chaotic sexuality," a concept that suggests immediately the significance in schizophrenia of psychosexual confusion in both susceptibility and expression.

In evaluating the place of physical symptomatology with relation to the continuum from hysteria to schizophrenia, certain physiological considerations are important, particularly regarding the autonomic nervous system. With a few exceptions, the functions of the autonomic nervous system are governed predominantly by either the sympathetic or the parasympathetic branch in complementary relationship. The tendency for one or the other branch to predominate has been discussed by Eppinger and Hess (38) as a tendency toward *sympathicotonia* or *vagotonia*, the latter named for the vagus nerve, which is an important component of the parasympathetic system. It may be stated in general that external, overt behavioral phenomena, such as movements of the limbs, sweating, and blushing, are facilitated by the sympathetic system: these activities tend to make heavy demands on the circulatory system, so that they are often characterized by increased heart and respiration rate. When they are exaggerated we can refer to a condition of sympathicotonia. Studies of neurotic patients by Wenger (146) and others show that these sympathetic phenomena are characteristic of anxiety and other neurotic conditions. While the sympathetic system facilitates these outer functions, it tends to inhibit inner, less obvious functions, such as digestive activity.

The parasympathetic system facilitates internal processes such as the secretion of digestive juices and peristaltic activity; these activities make relatively mild demand on the circulatory system, so that the heart is slowed.

In the emphasis on behavioral functions that are overt and socially active we can see a similarity between sympathicotonia and extratension. On the other hand, in the degree to which personal, internal activities are central to both, there is a similarity between vagotonia and introversion. While in psychotic behavior the significance of physical symptoms is less crucial than in neurotic patterns, it is important to note that internal disorders such as gastric

or duodenal ulcer tend to develop in individuals who are more introvertive than are the individuals who develop skin diseases.

In the light of the emphasis we have given to sexuality in the discussion of the hysteria-schizophrenia continuum it is interesting to note that sexual function is facilitated by parasympathetic activity and inhibited by the sympathetic. Thus, it is not uncommon to find in neurotic individuals disturbances of sexual function such as amenorrhea and frigidity in neurotic women and impotence in neurotic men. In schizophrenia, on the other hand, active sexual expression such as masturbation is often very prominent, and it is not therefore surprising that a function such as penile erection is parasympathetic or vagotonic.

These physiological considerations of the hysteria-schizophrenia continuum suggest that there is not only a female-male parallel but also a correlate of sympathicotonia-vagotonia. According to Eppinger and Hess (38), in the vagotonic (the individual whom we have related to the masculine, schizoid pole) sexual excitability, penile erection, and spermatorrhea are common. These authors point out that vagotonic women reveal masculine characteristics of hair distribution, body proportions, and the like.

Further along these lines of physiological observation, it is of interest to make at least passing reference to some studies by Beach (12). These studies were made, it is true, with animal subjects, but they suggest that, while damage to the higher (cerebral) centers of the male is considerably effective in reducing the sexual competence, such treatment leaves the female in this respect entirely functional. These studies show also that exteroceptive sensibility such as vision is of vital importance in the sexual arousal of the male, whereas in the female (this exteroceptive sensibility being of lesser or minimal importance) sensory reception by means of tactile stimulation is of primary significance. While it is always unwise to make inferences from animal experiments regarding the psychology or physiology of man, there is suggested from these studies the possibility that in the human male sexual expression involves exteroceptive impressions and cortical (ideational) factors considerably more so than in woman. Mating ability in the female, involving forebrain activity considerably less than in the male, is to a much greater extent a function of subcortical, vegetative integrity.

In the following discussion of solutions to anxiety—ranging from the extratensive to the introvertive—we shall as we progress from

hysteria to schizophrenia see a decrease in the focal significance of physical symptoms, of heterosexuality, and of social awareness. We shall see a complementary increase in the focal significance of inner elaborations in solutions to frustration that relate to older rather than recent conflicts, solutions in which heterosexual orientation and physical symptoms become incidental.

Neurasthenia

A neurotic solution close to hysteria in that the emphasis is on somatic illness is *neurasthenia.* Characterized by hypochondriasis and the systematized conviction of illness, neurasthenia differs from hysteria principally in the fact that in neurasthenia illness is subjective and internalized rather than expressed in socially obvious symptomatology. Because its symptoms are so convincingly those of organic illness such as tuberculosis, undulant fever, thyroid dysfunction or anemia, the diagnosis of neurasthenia is very difficult. The patient is weak, easily fatigued, and incapable of sustained effort. He usually has many and varied complaints of headache, back, chest, and abdominal pains. Typically, however, these specific complaints are generalized and vague; the most prominent complaint is one of general *malaise.* To the neurasthenic his illness is very real; in this respect he is like the hysteric. Unlike the hysteric, he is much less open to the suggestion that his illness is related to psychological factors; indeed, he is likely to resent being told that his symptoms as shown by careful physical examination have no organic basis.

Neurasthenia is a solution occurring usually in individuals whose history reveals the persistent utilization of illness as a means of solving difficult problems. The neurasthenic relies little on outward social impression; he is more likely to take refuge in the inner-elaborated conviction of illness. Irrespective of what the physician may think, the neurasthenic believes that his illness is real; he is as a result a chronic invalid. He is so fixed in his inner conviction of chronic illness that it is often difficult for him to achieve satisfactory readjustment.

Important in the diagnosis of neurasthenia is accurate physical examination, including blood tests (hemoglobin, leucocyte count), basal metabolism (for thyroid deficiency, infection), and tuberculosis tests. Indeed, in the differential diagnosis of neurasthenia it is most important as the first step to rule out all organic factors that

might account for such generalized illness. Eliminating the possibility of physical disease, it is important next to be convinced that the illness emerged as the solution to frustration. Usually in true neurasthenia there is a long history of repeated refuge in vague, generalized illness.

Thirty-two of the items of the Minnesota Inventory contribute toward a score for *hypochondriasis*, the important feature of neurasthenia. Of these items, only 8 measure *hypochondriasis* alone; the remaining 24 items also measure *hysteria*, *depression*, or *schizophrenia*.

The items that score alone for *hypochondriasis* are:

Answered "True"

There seems to be a fullness in my head or nose most of the time.
The top of my head sometimes feels tender.
Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep."
I have a great deal of stomach trouble.
I am bothered by acid stomach several times a week.
I am troubled by discomfort in the pit of my stomach every few days or oftener.

Answered "False"

I hardly ever feel pain in the back of my neck.
I have had no difficulty in starting or holding my bowel movement.

There are no items that contribute toward scores for *hypochondriasis* and *psychopathic deviate* alone. Ten items contribute scores for both *hypochondriasis* and *hysteria*. These are

Answered "True"

Often I feel as if there were a tight band about my head.

Answered "False"

I do not tire quickly.
I have very few headaches.
I seldom or ever have dizzy spells.
My eyesight is as good as it has been for years.
I can read a long while without tiring my eyes.
I have few or no pains.
My hands and feet are usually warm enough.
I am almost never bothered by pains over my heart or in my chest.
I hardly ever notice my heart pounding and I am seldom short of breath.

The fact that more items measure both *hysteria* and *hypochondriasis* than measure the latter alone is a reflection of the consider-

able hysteric component of *hypochondriasis*. That there is, however, at least a slight overlapping between the neurotic variables and schizophrenia is shown by the occurrence of three items contributing toward scores for *schizophrenia* and either *hypochondriasis*, *hysteria*, or both. These items are

Answered "True"

I have numbness in one or more regions of my skin.

Answered "False"

I have had no difficulty in keeping my balance in walking.
I have little or no trouble with my muscles twitching or jumping.

The two case reports following are presented by McKinley and Hathaway (97) as illustrations of the utility of the Minnesota Inventory as an aid in differential diagnosis of neurotic in contrast to tissue-pathologic illness.

1. A man aged 22, unmarried, entered the University Hospital on April 1, 1940 because of headache, tinnitus and tenderness of the scalp. He had been followed in the medical and neuropsychiatric clinics for about two months and was then hospitalized because he was making very little progress and intensive management seemed indicated.

The relevant scores on the Minnesota Multiphasic Personality Inventory were hysteria 84 and hypochondriasis 67. The other scores were well within normal bounds, though the depression score was slightly elevated, namely 58.

The patient's illness began in the summer of 1937, when he was working in an ore mine in Bemidji. He was unable to keep up with the amount of work the other boys of his age were accomplishing; they teased him about his low output. After a time he began to have mild pain in the back and his appetite decreased. He began then to use these symptoms as the reason for his inability to keep abreast of the others. On returning home in the autumn he consulted an irregular practitioner, who placed him on a meat free diet which he observed for over a year. Subsequently he became anemic and because of this, he said, his friends, particularly the girls, began to avoid him, and he turned gradually from a life of physical activity to one of concentration on his junior college studies and interest in trumpet playing. In October 1939 he first noted a dull headache which was bothersome only when he was studying. This gradually became more severe and by Christmas time he could not study at all. The headache disappeared during Christmas vacation, and he worked well in school for three days after the holidays, but then it recurred so severely that he quit school entirely. The headache was persistent from that time and kept

him continually at home until he appeared at the outpatient department seeking relief.

The patient had always been a fairly well liked boy, somewhat inferior physically but respected for a relatively superior intellect. He was described as kind, unselfish, well behaved and not suspicious. However, he desired to be a leader among the boys and he would make excuses when he could not function as the leader. His moral code was always high. He was rather sky and afraid that people were ridiculing him for some indefinite reason.

The family was Slavonian by derivation. The father had been working on WPA, making about $45 a month. The mother had been very solicitous of the patient and acted toward him as if he were the baby of the family needing her protection against the others.

The examination and laboratory studies revealed no serious abnormalities.

The patient's mental status in the hospital corresponded with the anamnestic data. He continually worried about his health and as to whether he would be able to return to school and become a journalist. He complained about many vague and indefinite aches and pains such as eye strain, headaches, backache and anorexia. He asked "Why must I have these headaches?" and said "These headaches are real to me and are severe, even though people might not think so." He stated that he desired to get well and go home. He was oriented in all spheres, did arithmetical problems rapidly and accurately, was well informed on general topics and displayed common sense in matters not connected with his illness. He appeared somewhat anxious, sad and depressed. He declared that he understood that the headaches were functional and could define what is meant by a functional headache; however, his general demeanor was not altogether in accord with this verbal insight. He talked slowly and tried to recite accurately and in detail all of his bodily complaints. On one occasion he made up a list of his complaints so that he could approximate completion of his descriptions of himself in order to make sure that he got all the topics assembled. His attitude and manner and his general appearance were usual for his social level. He was open and accessible to the examiner. On occasion he appeared relatively happy and joined in the activities in the ward with obvious enjoyment.

The patient gradually improved under the hospital care. Following a lumbar puncture a second headache developed which he recognized as quite different from his ordinary cephalalgia; both slowly disappeared. Five days after the puncture he also complained of a pain in the back which he ascribed to the puncture, but he located this pain two vertebral levels above the actual site. This too disappeared, and then all of his complaints began to diminish until finally they were gone. He became interested in his surroundings and requested his discharge because he was

feeling so well that he thought he should return home and go back to his school work. He was discharged on April 24, 1940.

The final diagnosis was psychoneurosis, hypochondriasis. The notation was made that, considering the rapid improvement in the hospital environment, the outlook for this boy was probably good if he is not placed under much stress. (Pages 164–165.)

2. A woman aged 25 first came to the University Hospital outpatient department in October 1936, at which time she complained of diplopia when looking to the right, blurred vision, numbness and tingling of the radial portion of the right arm and hand and numbness of both legs. These symptoms had been present for only a few days. The patient said that she had had headaches all her life which were worse in damp weather and appeared mornings and disappeared during the course of the day.

Direct examination medically and neurologically was essentially negative except for a slight decrease in hearing bilaterally and, on ophthalmoscopic examination, slight, probably physiologic blurring of the left disk margins. Most of these symptoms disappeared within a few weeks except for numbness in the finger tips. It was considered that the patient was suffering with a psychoneurosis, but multiple sclerosis could not be satisfactorily ruled out.

In November 1937 she had a tooth pulled and shortly thereafter there was partial blindness in the right eye. The blindness disappeared within a few weeks, but about a month later, following an attack of tonsilitis, the blindness recurred. Tests for visual acuity at this time revealed 1/100 in the right and 20/15 in the left eye. It was noted that she had some sinus tenderness, and the ophthalmologist thought that she had an optic neuritis on the right with a central scotoma, probably the result of the tonsilitis. The tag of a tonsil was removed and vision returned to 20/25 within a few weeks. She complained somewhat at the time of pain in the back of the neck. She stated that she was rather nervous.

She had no trouble then until December 1939, at which time numbness and tingling recurred in the right leg and her gait became somewhat unsteady, with a tendency for her to fall toward the right side. She stated that she had had occasional attacks of numbness and tingling of short duration in the left lower extremity and in the left hand. Examination now revealed the following findings: The knee jerks were rather strongly increased and the abdominal reflexes were absent except in the upper quadrants, where they were reduced but equal. She had paresis in flexion and extension of the right leg and in plantar flexion of the right foot; she was unable to perform dorsal flexion of the foot. There was decreased sensibility to cotton and pin from the right hip downward.

The eyegrounds were still equivocal for slightly indistinct margins. During examination she cried several times and indicated that she was not happy in her family relationships but would not discuss the matter at all.

Multiple sclerosis still seemed a distinct possibility, but the staff was more impressed at this time by the emotional reactions of the patient. She returned in April 1940. The examination revealed slight nystagmus and hyperactive knee jerks. The left biceps was increased over the right. There was definite weakness of the right leg. Vibration sense seemed reduced, but the patient's responses were somewhat equivocal. It was then considered for the first time that the patient definitely had multiple sclerosis. Subsequently her condition has developed into a typical severe multiple sclerosis.

During her hospital stay in 1940 the personality inventory was administered and it was somewhat surprising to find her scores all within the normal limits: hypochondriasis 62, hysteria 49, psychasthenia 42, depression 46. Evidently this patient was well equilibrated in her basic affect. Most of the symptoms that had given rise to the impression of hysteria were actually early evidences of the disseminated sclerosis. Her peak score of hypochondriasis 62 probably represented her concern over her illness, which was indeed organic.

The findings of a normal personality profile in this patient, who was long suspected of presenting conversion symptoms, were potent evidence of the probable mistake in such an interpretation. In retrospect it is obvious clinically that multiple sclerosis was developing and that the fluctuating sensory and motor symptoms actually represented the onset of the disease. This diagnostic dilemma in differentiating hysteria from multiple sclerosis is an old one which is still bothersome even to the experienced neurologist. The inventory is thus shown to have value not only in demonstrating the presence of a psychoneurosis but also when it is within normal range, in giving precision to one's thinking in ruling out psychoneurotic reactions in cases of uncertainty. (Pages 165–166.)

Predominantly neurotic, the Rorschach picture of the neurasthenic usually combines elements of repression with extratension. Frequently revealed are anxiety features. An expression of anxiety particularly neurasthenic, according to Klopfer and Kelley (81), is the restrained use of movement. Responses that represent figures as bending or hanging are considered to be typical of the restrained elaboration or projection of the neurasthenic; mildly and tentatively they are responses in the direction of introversion, expressive not so much of personalized or bizarre elaborations as of anxiety and uncertainty.

Like hysteria and anxiety, neurasthenia is considered to be a form of neurosis. Although there are elaborative elements, the neurasthenic's elaborations are in no sense like the psychotic dealing with reality. Systematized within, the neurasthenic patient's illness

represents a personalized solution quite compatible with society, such that the orientation can be considered largely extrovertive.

Psychasthenia, or the Obsessive-compulsive Solutions

A group of solutions often encountered and frequently complicated by psychosomatic features are the obsessive-compulsive neuroses, sometimes designated as *psychasthenia.* This solution to frustration is characterized typically by intense awareness of social values (in this sense it is extratensive) and by the elaboration of intellectualized fears, activities, and ideas that are exaggerated and dominant. These inner elaborations may limit or govern the individual's entire effectiveness.

Developed as means of averting the personal threat of insecurity, frustration, and anxiety, the specific and unreasonable fears known as *phobias* originate in quite natural fear, but they become fixed and systematized to such an extent that they cannot be ignored. Phobias may be characterized by fear of open places, fear of high places, fear of being shut in spatially, or fear of specific objects, such as blood, dogs, snakes, etc. Such systematized fear is considered theoretically to develop as a projection of the individual's personal anxiety onto aspects (objects) of the environment. Thus, anxiety in the compulsive-obsessive personality is not free-floating anxiety; as in hysteria, it is converted toward a specific outlet but toward an outlet which, unlike that of the hysteric, has characteristics of personal elaboration as well as socially obvious symptoms of illness.

Just as an unreasonable fear may be central to the patient's personality, so may compulsive acts—*i.e.*, acts that are ritualistic attempts to counteract the threat of danger. Typified within the normal range by a passion for punctuality, neatness, and order, such acts may in extremity become master of the individual's life adjustment. The urge toward cleanliness, for example, may be characterized by an extreme necessity to wash one's hands over and over again. Some individuals cannot eat in a restaurant without first wiping each piece of silver with a napkin. This inordinate ritual, developed to avoid contamination, stems possibly from the quite natural fear of infection, but it may be carried to such an extreme that unless his ritual is carried out to the letter the individual is unable to maintain composure. The relation between compulsion and fear is well illustrated in the individual who, fearing intrusion into his house, gets out of bed and goes downstairs to see that the

door is locked; returned to bed he wonders whether the door is *really* locked, so goes below once again—and then again—acting out aggressively a defense against threat.

The term *obsession* is used to designate an idea that, no matter how unreasonable and exaggerated, is nevertheless so fixed that it is a dominant pressure or limitation upon the patient's daily life. The passion for cleanliness may originate in the conviction that all milk bottles carry the undulant fever germ, an idea that is obsessive. Yet this conviction may be so intense that the patient is forced to deny himself milk entirely.

Many of the formalized aspects of our society represent socially tolerated and accepted compulsions. We have only to consider the rigidity of requirements in dress, table manners, personal hygiene, etc., to find examples of social compulsions. However, just as the formal aspects of society seem to have developed more significantly for some individuals than for others, so do some persons tend more than others to develop highly personal exaggerated compulsive tendencies. These seem usually to be related to values that are social, such as prestige, respectability, wealth, and social position. In his saving the miser is compulsive; likewise, even in his philanthropy the business magnate is governed by a need for system.

Often related to personal hygiene, the salient aspects of the personality of the obsessive-compulsive individual frequently are revealed in concern about dress, the arrangement of shoes in the closet, neatness of the clothes chest, etc. Particularly important are toilet habits. Indeed, according to some theorists the psychogenesis of obsessive-compulsive behavior has its origin in the stages of infantile psychosexual development during which achievement of satisfaction in nutritional, digestive, and eliminative functions (receiving or rejecting, retaining or giving) is of greatest significance.

Often prominent in the personality of the compulsive-obsessive individual are factors of aggression and hostility. Compared with the hysteric and neurasthenic solution, the obsessive-compulsive is an *active* rather than a passive process. The compulsive individual seeks actively to avoid insecurity by making money—lots of money—more than he needs. By *doing something* hygienic and preventive, he seeks to avoid contamination.

As might be expected from the foregoing, the organic illnesses that obsessive-compulsive individuals are most likely to develop are often associated with gastrointestinal functions—food finicalness, per-

sistent vomiting, digestive upsets, constipation, and diarrhea. It is such individuals who tend to develop chronic intestinal spasm or ulcer of the stomach or duodenum. The ulcer patient is an individual usually of driving ambition with a desire to get ahead, to proceed systematically toward goals that frequently are associated with prestige and material wealth. Often, if not usually, the symptoms of ulcer are preceded by a particularly dramatic frustration of prestige values. The individual is thwarted by his boss once too often; he may become aware suddenly that he lacks the capacity to fulfill a position of responsibility and good pay.

In the premium he places on health, it is apparent that the obsessive-compulsive individual is related to the neurasthenic. Whereas the neurasthenic is likely to feel that his illhealth is naturally the concern of his physician, the obsessive-compulsive is more likely, short of organic lesions, to take some definite hygienic position on his own, whether it be the initiation of a regimen of daily vitamins, setting-up exercises, sodium bicarbonate, or an enforced fishing trip with the latest of equipment, complete. Such an individual is likely to have a medicine chest well stocked with multiple remedies. To the obsessive-compulsive, life's frustrations are a challenge to be met personally and actively, not as they are met by the hysteric and neurasthenic, passively. In anticipation of the threat of insecurity, the obsessive-compulsive seeks to avoid it by means of preventive measures that are systematic. When illness develops, it is likely to be an unpleasant and interruptive burden, much less tolerable than to the hysteric. Indeed, physical illness need never develop in the obsessive-compulsive; incapacitation is as likely to result from inordinate enslavement to phobia or ritual or obsession as it is from physical illness. The kernel of the obsessive-compulsive personality is to be found in this personal elaboration of artificial and unreasonable system and ritual, motivated as deliberate defense against threat to personal security. Inadequate though it is this form of neurotic solution is an active, aggressive, masculine achievement (found nearly four times as frequently in men as in women). It is also an elaboration that when carried to extremes may approximate the delusional and even the psychotic. Of the various neurotic solutions, the obsessive-compulsive, because they often appear illogical and distorted, are nearest the psychotic. It is probable that certain of the distortions of motivation discussed in Chap. IX (such as pyromania, fetishism, and voyeurism) involve

obsessional and compulsive features—drives that the individual himself recognizes to be incompatible with successful adjustment but of such personal importance in the reduction of anxiety or in the achievement of satisfaction that they cannot be adequately repressed.

From the foregoing, it is seen that to the obsessive-compulsive individual prestige values are usually important—a fact that indicates that this solution is, at least in part, socially oriented. But it is apparent also that of central significance are the personally elaborated projections. Often the dominant motivational pattern of the compulsive-obsessive is one of aggression and hostility, even though frequently disguised as philanthropy. In the psychogenesis of the compulsive personality, the repression of hostile impulses is frequently found to be characteristic. Indeed, in the personalities of individuals who characteristically develop psychosomatic solutions such as high blood pressure, gastric ulcer, coronary occlusion, and migraine, elements of long-repressed hostility are often found to be of primary significance. Individuals who develop such inner disease frequently are socially ambitious persons who outwardly are successful, pleasant, and adjusted but who tolerate frustration poorly. When thwarted it is necessary for them *consciously* to exert control. Under conditions of emotional tension with its digestive and other physiological changes, physical symptoms have a splendid opportunity to gestate.

As we proceed from hysteria through neurasthenia to the obsessive-compulsive neuroses, there is a tendency, though with wide individual variations, for intellectual capacity to become greater. In the obsessive-compulsive neuroses we frequently find intellectual superiority—a finding rare in hysteria.

Test performances. On tests obsessive-compulsives reveal themselves rather clearly.

Of the items of the Minnesota Inventory, 48 contribute toward a score for *psychasthenia*; 19, or 40 per cent of these contribute toward this score alone (or with masculinity-femininity). The remaining 29 items contribute in varying degree toward all the other Minnesota variables except *hypochondriasis*. The items that measure *psychasthenia* alone are

Answered "True"

In school I found it very hard to talk before the class.
I am easily embarrassed.
I easily become impatient with people.

I feel anxiety about something or someone almost all the time.
Sometimes I become so excited I find it hard to get to sleep.
I forget right away what people say to me.
I usually have to stop and think before I act even in trifling matters.
I have a habit of counting things that are not important such as bulbs on electric signs, and so forth.
Sometimes some unimportant thought will run through my mind and bother me for days.
Bad words, often terrible words, come into my mind and I cannot get rid of them.
Often I cross the street in order not to meet someone I see.
I get anxious and upset when I have to take a short trip away from home.
I have several times given up doing a thing because I thought too little of my ability.
I am inclined to take things hard.
At times I think I am no good at all.
I frequently find myself worrying about something.[1]

Answered "False"

I almost never dream.
I like to study and read about things that I am working at.
I have no dread of going into a room by myself where other people have already gathered and are talking.

Three items contribute toward scores for *psychasthenia* and *psychopathic deviate* only:

Answered "True"

I do many things which I regret afterwards (I regret things more or more often than others seem to).
Much of the time I feel as if I had done something wrong or evil.
My hardest battles are with myself.

With *hysteria* or *hysteria-hypochondriasis*, *psychasthenia* is scored on the following two items:

Answered "True"

There seems to be a lump in my throat much of the time.

Answered "False"

I wake up fresh and rested most mornings.

These duplicate weightings suggest that the *psychasthenia* variable as measured by the Minnesota Inventory overlaps slightly with the *psychopathic deviate* and *hysteria-hypochondriasis* variables. That its

[1] Scores also for masculinity-femininity.

overlap with *schizophrenia* is greater, however, is revealed by plural scoring on the following five items:

Answered "True"

I have strange and peculiar thoughts.
Almost every day something happens to frighten me.
I have been afraid of things or people that I knew could not hurt me.
Life is a strain for me much of the time.
I have more trouble concentrating than others seem to have.

The following item contributes a point toward scores for *psychasthenia* and for both *hysteria* and *schizophrenia* (answered "True"):

Most of the time I feel blue.

With the Thematic Apperception Test, Masserman and Balken (96) report that

> The phantasies of obsessive-compulsive patients are mainly characterized by a pervading uncertainty—a sort of fruitless, querulous indecision in which the subject may even appeal to the examiner for help with the problems presented by his own fancies. Moreover, in many cases, there is a frequent recurrence of a few clearly related, almost stereotyped phantasies expressive of great ambivalence about important emotional conflicts, and usually given at great length and in meticulous detail. Phobias, when present, are included in the phantasies, often with intensely dynamic connotations. (Page 86.)

On the Rorschach, in addition to the generally neurotic characteristics such as color shock and repression, the compulsive may often demonstrate exaggerated tendencies to give wholes, to account for every part of the figure, to give a large number of responses, or to limit himself carefully to some particular aspect of the blots, such as outer details. Compulsives frequently betray themselves in a persistent tendency to choose one type of response, such as to look carefully for profiles along the edges of the blots. Anxiety in the psychasthenic is likely to be revealed thus indirectly—not so much in cloudy responses or responses of dubious prestige value as in responses that suggest some *active*, participatory manner of relying on a particular form of response apparently considered impressive, safe, or reliable.

Epileptic Behavior

The predominating opinion among students of epileptic behavior is that the tendency to seizures is largely determined by a specific condition of the brain itself characterized by an unusual form of

neural activity, described as *cerebral dysrhythmia.* While it is believed that as many as 15 per cent of the population demonstrate the dysrhythmic pattern on the EEG, and that only a small proportion of this group actually have epileptic seizures, nevertheless this dysrhythmic pattern is considered to be that of the essentially epileptic individual; those dysrhythmics who do not have seizures are regarded as potential epileptics. In the quest for explanation of the presence of the dysrhythmic pattern, much credit has been given heredity, for members of the same family tend to demonstrate similar patterns on the EEG. The dysrhythmic pattern may also appear following injury to the brain. Because of this physiological evidence and because of the fact that by means of drugs these neural concomitants (and the seizures) may be reduced at least in some individuals, there is a widespread tendency to neglect psychodynamic aspects of convulsive behavior.

For several reasons epileptic behavior is of primary concern to the psychopathologist as well as to the neurologist. In the first place, the epileptic attack is often misinterpreted as hysterical, and vice versa. Secondly, epileptic seizures sometimes occur as a phase of complex neurotic and psychotic behavior and sometimes in association with mental deficiency. There is often concomitant evidence of psychological deficit similar clinically to that shown in cases of brain injury. Lastly, one form of seizure considered epileptic but lacking the motor aspects of the classic convulsion is characterized by paroxysmal, uncontrolled outbursts of hostility, often of homicidal degree, which are entirely irrational and hence psychotic.

The condition known as *epilepsy* is characterized by sudden paroxysmal seizures of varying severity and frequency, episodes in which there is a loss of consciousness and for which the patient has later no recall. The *grand-mal* seizure is characterized by convulsive behavior involving practically the whole body. In the *petit-mal* attack the only symptom may be a momentary loss of consciousness. Epileptic attacks may appear following brain injury, but they may also appear quite spontaneously, as if arising from no physical accident whatever, in which case they are referred to as "idiopathic."

The *grand-mal* seizure is sometimes preceded by an experience on the part of the patient that acts as a forewarning, usually a sensation of tightness or dizziness or of tingling in some part of the body. This sensation, called the *aura,* may be in some instances visual or auditory, and sometimes it may approximate an halluci-

natory phenomenon. The aura occurs immediately prior to the seizure, usually allowing the patient no time to seat himself or take any other measure to prevent falling. Consequently, epileptic patients are frequently hurt. They often bite the tongue severely, and in conjunction with the generalized bodily convulsion they may urinate and defecate. Obviously the imminent possibility of attack means that the patient exists at all times in a situation potentially dangerous to himself and (as in driving a car) to others.

Grand-mal seizures appear sometimes though not necessarily in individuals who suffer or have suffered from *petit-mal* attacks, and the incidence of both types of seizure seems to occur in association in rare instances with the periodic and intense headache known as *migraine;* the tendency to migraine has been known to be replaced by the tendency to epileptic attack (106).

Epileptic attacks may be induced by electrical stimulation of the motor areas of the cerebral cortex. They may be induced in some patients by the forced administration of water (together with a pituitary extract). This is a technique often used diagnostically to determine whether or not the patient with a history of convulsions is actually predisposed to the truly epileptic seizure. Convulsions similar to the epileptic appear following both electric shock and the administration of metrazol.

While it is generally held that the epileptic seizure may be precipitated in an intensely emotional crisis, there is considerable controversy regarding the degree to which epileptic behavior is environmentally determined, and there have been few suggestions that the seizure represents a reduction of anxiety—a solution to conflict in any way resembling neurosis or psychotic elaboration.

Typical epileptic convulsions have been observed to be precipitated by a particular stimulus situation.

One patient, a man of 23, who had suffered typical epileptic convulsions for several years, when asked what seemed to induce his seizures, stated that, among other things, the sight of a hypodermic needle often precipitated them. Some hours later, his physician,[1] after warning him that he was going to give him a "shot," then prepared a hypodermic within full view of the patient, whereupon the patient exhibited a typical *grand-mal* convulsion.

We do not know in this case what specific psychological valence

[1] Dr. W. M. McGaughey, to whom the author is indebted for this case reference.

the hypodermic needle possessed for this patient, but it is possible that it was involved in some situation pertaining to earlier conflict and that for this reason it served to arouse intense anxiety. An instance has been reported in which the aura preceding typical epileptic attack—the experience of the visual image of a vase—was found related to childhood associations with the patient's mother. The great preponderance of seizures seem to occur quite irrespective of the immediate environment. Nevertheless, the demonstration that in at least some instances epileptic seizures may be precipitated by specific objects in the environment or by certain experiences related to earlier conflicts suggests that psychodynamic factors may be of significance in all cases.

Although the epileptic convulsion can hardly be considered an experience pleasant to the patient, since it is so often harmful to him and may occur at critical points of embarrassment and even personal danger, there are reasons to believe, nevertheless, that the convulsion may serve real utility. In support of this hypothesis, let us consider the following. The use of shock therapy in some cases of psychosis suggests that the convulsion here serves some real purpose in bringing about a more satisfactory relationship to the real environment. Interpretations of the theory of action of shock therapy differ: it has been considered that the convulsion somehow shakes the patient loose from his narcissistic withdrawal from the world about him and reawakens an interest in the environment. Some have suggested that the experience of the convulsion is an experience essentially of death and that the rebirth following the convulsion is a powerful reminder of the pleasure of life. It is interesting that the shock is most effective therapeutically in cases of depression, in which preoccupation with death is often central (62, 99, 126). Observers have commented that some patients report the post-convulsive state as one of exhilaration.

Bartemeier (10) has traced the similarity between the epileptic convulsion and the convulsive starts in the presleep period that are experienced by normal individuals. He feels that the convulsion may be an automatic means of achieving relaxation necessary to sleep and points out that the experience of orgasm, also convulsive, is followed also by relaxation. It has been reported to the writer that some patients, particularly women, recall the experience of epileptic convulsion to be a satisfying one, and that at least some women experience orgasm as a part of the seizure.

The epileptic convulsion has been considered also to be a means for the discharge of repressed hostility, similar in this sense to other psychosomatic outlets such as gastric and duodenal ulcer, hypertension, and possibly diabetes, but differing from these in its paroxysmal rather than chronic expression. Possibly the fact that the seizure designated as "psychic equivalent" is an expression of intense hostility is important in this connection. It is the writer's experience that in the early history of adult male patients who show convulsive tendencies there is frequent evidence of intense hostility, particularly toward the father.

Though controversial, the question as to whether there is or is not a pattern of epileptic personality has been raised persistently for years. Many observers have remarked on the consistency with which epileptics seem to reveal certain personality traits. At least one personality test (68) provides a score designated as an index of the epileptoid personality. The following discussion by Noyes (105) is pertinent:

Reference is often made to a so-called epileptic personality. Many but by no means all epileptics do manifest unpleasant personality characteristics. One is not justified, however, in saying that there is a constellation of personality traits always found in persons with epilepsy and found nowhere else. Undoubtedly some epileptic children are irritable, restless, overactive, moody, stubborn, oversensitive, shy and may manifest such conduct disorders as lying, stealing, fighting, sex misbehavior, cruelty and destructiveness. By no means all epileptic children show these characteristics. If they exist they are probably due to bad home environment and to the frustrations, social rejection, state of insecurity, constant anxieties and other emotional difficulties arising from the child's handicap. Psychiatrists whose contacts with adult epileptics are limited to institutional patients usually assert that the epileptic has a rigid, unpleasant, irritable, self-centered personality given to rage on frustration. On the other hand physicians who see no epileptics except those met in office and clinic report that their patients do not exhibit more undesirable traits than do persons free from the disease. Undoubtedly, however, the patient who feels that he is handicapped through his disorder, who fears exposure and is convinced that he is destined to be an abnormal member of the family has periods of irritability and depression. The sense of resentment which he often feels may produce unhappiness, add to his problem of adjustment and perhaps create anti-social tendencies. Discouragement and hopelessness may lead to contraction of interests and mental slowness. The religiosity shown by some epileptics may have its origin in a search for security, solace and self-esteem.

Rorschach studies of patients who suffer epileptic seizures reveal wide variability among them. Harrower-Erickson (58) feels that homogeneity is so slight that no pattern may be considered typical. Both Rorschach (119) and Guirdham (53) stressed certain features of rigidity, poor form, and the rather direct use of color—features that they felt definitely associated with the convulsive tendency. Made largely on advanced and even deteriorated epileptics, these Rorschach observations show, as we might expect, a similarity between the epileptic picture and that for other forms of brain damage. However, with the organic's tendency to paucity of response and perseveration, the long-standing epileptic tends to give a generally better record qualitatively. Tending to use color and color-form more than form-color, the epileptic patient's use of color thus approaches the psychotic use of color and suggests, as Klopfer and Kelley (81) point out, a disturbance in emotional expressiveness.

Naturally, one can take the position that the threat of imminent convulsion itself might well explain much of the epileptic patient's peculiar personality, if such it be. Lennox (89)[1] feels that the number of patients that reveal peculiarities of behavior is small, and that the traits "for the most part are a result of the seizure state, either of the associated pathology of the brain, the mental deterioration, the action of sedative drugs, or the effect of ostracism" (Page 962). Certainly it is generally accepted that the epileptic patient is usually defensive and evasive regarding his tendency. One of the greatest medical-recruiting problems during the war was to keep the epileptic individual out of the service. Not only did epileptic individuals appear in greater proportion among volunteers than among inductees (88), but they usually revealed great distress at having their tendency exposed.

In explaining the personality of the individual who tends to have convulsions it is undoubtedly of importance to consider the constant threat of danger. We feel nevertheless that the seizure must also be considered a psychosomatic expression of the personality. The epileptic personality has much in common with the personalities that seem predisposed to certain other psychosomatic manifestations, such as migraine, hypertension, heart disease, and diabetes. These are diseases the symptoms of which, in contrast to hysteria, are inner rather than obvious and the onset of which is insidious. Thus, the

[1] Reprinted with permission of The Ronald Press Company from *Personality and the Behavior Disorders*, J. McV. Hunt (ed.).

personality of the epileptic individual is less socially oriented, more elaborated within; characterized as it is by repression and evasiveness, we could think of an epileptic tendency to withdrawal. Though the epileptic convulsion is similar to hysteria in its drama (and therefore often misinterpreted as an hysterical attack), the very factor of social utility mainly distinguishes the two psychologically. The seizure occurs in the hysteric for the purpose of attracting attention socially, to gain sympathy or approval of incapacity. The epileptic convulsion, on the other hand, occurs despite the patient's efforts to forestall it. In the seizure the hysteric individual rarely hurts himself physically, while the epileptic cannot prevent injury.

The relation between the convulsive tendency and psychosis is an interesting consideration. We mentioned the fact earlier that epileptic seizures are followed sometimes by definite psychotic manifestations, such as hallucinatory and delusional phenomena. Cases have been reported in which, under drug therapy, convulsions were eliminated, only to have psychotic manifestations appear in their stead. It has already been mentioned that the deliberate production of convulsion (by electric shock) seems in many cases of psychosis to relieve the depression of the patient and to render his relationship to reality more satisfactory.

In the evaluation of the convulsion as an hysteric or typically epileptic phenomenon, probably the greatest aid is to be gained from the electroencephalographic recording; next in importance is the opportunity to observe the seizure and the setting in which it occurs. The nonepileptic seizure usually lacks the aura, tongue biting, injury to the person, and urination or defecation. The epileptic attack may occur in bed as well as during the day and while the patient is alone as well as when he is with others. Neither of these unsocial possibilities is likely in hysteria. Although amnesia for the attack may be characteristic of hysteria, it is always true of the epileptic attack.

When these objective and observational criteria afford positive evidence of the epileptic nature of the convulsion, it is usually unnecessary for purposes of diagnosis to explore personality factors. But because the EEG is often unobtainable and because observations of the seizures are often unconvincing, it is usually of significance diagnostically to determine whether or not the patient is typically hysterical or whether certain aspects of the personality suggest a more elaborative dynamics. Common to both hysteria

and epileptic tendency are factors of egocentricity, but whereas the hysteric is only too glad to emphasize his illness, the epileptic is more likely to minimize it. Whereas both personalities may reveal repressive and anxious features, the hysteric is suggestible and personally interactive, while the epileptic patient tends to rigidity. Where evasiveness, suspicion, and resentment are present, repression seems more likely to be that of the epileptic's hostility. The hysteric's repression is in the form of anxiety about social success, of making an impression, or of achieving attention. It is particularly where we find tentative suggestion of psychosis that we suspect epileptic tendency rather than hysteria. Although psychotic phenomena are by no means essential components of the epileptic personality, when they exist together with seizures that appear epileptic they are confirmatory of the epileptic rather than hysteric diagnosis. Indeed, some instances of epileptic seizure seem to be psychotic outbursts of hostility, the so-called "psychic equivalent" of epilepsy.

The following case, from a report of Kupper (84), illustrates the dynamics of epileptic behavior in an individual whose attacks appeared following concussion at the age of nineteen.

J. S. was a 24 year old maritime service trainee who was sent to this hospital in December, 1943, after a convulsive seizure with tonic and clonic movements was observed by the service physician at his base. He gave a history of similar attacks occurring each month, starting in 1938. They began two months after a concussion sustained during a football game. The peculiarity was that the attack occurred only in the mornings before breakfast. The patient believed with what proved to be extraordinary insight, that it was due to "too much sleep." Also there were unusual clonic movements of the body prior to the attack. These motions occurred every other day without loss of consciousness.

Family history was negative for "epilepsy" and associated illnesses. Past history indicated no apparent neurotic traits in the background except for immaturity and great dependency needs. Psychosexual history was not markedly abnormal. He was married but found difficulty in accepting his responsibilities. After the initial attacks in 1938, he visited the University of Pennsylvania in 1940 and a spinal tap, head x-rays, electroencephalogram and air encephalogram were done to determine the cause of his seizures. Except for diffuse abnormality on the electroencephalogram, indicative of convulsive disorder, nothing abnormal was found. A repetition of these tests with the exception of a ventriculogram was done here and diffuse cortical irregularities consistent with a convulsive disorder were found. In December, 1943, the patient was observed

in an attack which embraced an aura of "floating" then unconsciousness, tonic and clonic movements. Tremendous physical activity followed and several men were needed to keep the patient from harming himself. The attack lasted 10 minutes and was followed by deep sleep.

The patient was successfully hypnotized but suggestion yielded no pertinent information. The patient was then told to spell any word or phrase which might be responsible for his attack. He spelled the word "hate" and was urged to dream of the people and circumstances relating to this. He then dreamed that his father was beating his mother and himself. He could not strike back because his arms were paralyzed in a similar manner to his feeling prior to an attack. Repressed emotions were released through the use of "free association" and for the first time an accurate re-enactment of the first attack occurred. This happened in 1938 one morning before breakfast when sitting at the table with his father. The latter was quarreling with his wife because she favored the patient by giving him more buns. The father became physically and verbally threatening. The patient recalled great tension, looking at a knife on the table with a fantasy of stabbing his father and then ran into the kitchen to hold his mother in his arms. He felt faint and the last thought before he lost consciousness was that he would commit suicide by putting his head in the gas oven in the home of his maternal aunt. He awoke with his mother comforting him. He did not soil himself or bite his tongue.

This material is condensed and does not describe the persistent daily exposure of additional material and the overcoming of unconscious and conscious resistances. Thereafter, the patient was placed in an hypnotic state and serial electroencephalograms were taken. He was taken back to his twelfth birthday and the E.E.G. reading was within normal limits. It remained so through succeeding suggested years until his eighteenth year in 1938 following the first attack. Then diffuse cortical abnormalities occurred. By suggestion the patient was placed in the situation prior to the initial attack on the fateful morning. More irregularities, abnormalities and slight spiking occurred. The record was then changed within normal limits by reassuring the patient and the series repeated. A convulsive seizure was produced and stopped while under hypnosis on suggestion of the examiner. Moreover, this could not be produced except by bringing up the specific triangular situation. Persistent work done with interpretive therapy over three months made his hostility toward his father more acceptable. In addition, the attack was shown to be a punishment for this unacceptable death wish against the father as well as a fantasy of being "cleansed" and "reborn." The patient always described feeling "fresh as a daisy" following an attack. He related that although he feared them, he looked forward to the aftermath. The prodromal

feeling of "floating" which occurred prior to a seizure was connected with his concept of suicide by gas as described in the initial attack. His almost daily clonic movements were traced to a morning in 1938. They started as he was sitting at the breakfast table with his father and when a hot cup of coffee was propelled at the father by the uncontrollable movements of his hands.

Repeated dreams were interpreted by the patient himself without suggestion. . . . Any threatening figure was interpreted as the father and most stationary ones as the mother. The content was invariably that of the father threatening the son and mother, while the son was "paralyzed" or powerless. The fear of "too much sleep" proved to be a fear of dreaming which always preceded an attack. In attempts to "resist" the patient would dream of a house filled with buns which everyone ate so that his father was appeased.

A Rorschach was done and there was no evidence of so-called "epileptic personality." Evidences of insight and change in character traits were recorded.

The patient was allowed to visit home on one occasion for a week, and in spite of repeated contact with his father suffered only tenseness. He has remained in close contact with his father without untoward effects. (Pages 16–17.)

Kupper makes the following summary of this case:

The uniqueness of this case is in the fact that in spite of undeniable constitutional or organic factors, the emotional overflow and the psychogenic precipitating factors were modifiable. It would be too early to claim a cure but a remarkable improvement was undeniable. The patient has been working and free from seizure for four months.

This case report emphasizes that emotional and psychogenic factors precipitated an "epileptiform" attack; and more important, that there was an emotional threshold, which if not exceeded, could prevent a seizure. In this man, the trigger to a convulsive seizure centered about a personal conflict whose resolution could lower the emotional danger point enough for clinical improvement. Under hypnosis and in interviews, only this emotional problem could produce an attack or a perceptible change in the electroencephalogram. The broad generalization for epilepetics to avoid "excitement," "upsets," and the like, is inadequate. Some particular unconscious conflict seems to be the one capable of producing a clinical change as evidenced by seizures in this patient. This can be the only explanation of how epileptics manage to undergo many daily environmental traumata and succumb to relatively few. Also noteworthy was the fact that unconsciousness offered the only solution for the intolerable conflict on the morning of the first attack. (Page 17.)

Paranoia

In the progression from hysteria toward schizophrenia we have seen an increasing tendency toward personal elaboration and, as in the personalities of the obsessive-compulsive and the epileptic, a tendency for personal elaboration to become increasingly irrational and unreal. In the obsessive-compulsive neuroses this is revealed in the occasional extremity of phobia or ritualistic acts that is out of proportion to reality. In the discussion of epileptic behavior we saw the psychotic degree to which the psychic equivalent is expressed in complete irresponsibility and even murderous behavior.

Related in many ways very closely both to obsessive-compulsive outlets and to epilepsy is the reaction type known as the *paranoid.* Particularly important in this connection are the subjective elements of inner, logical, systematic elaboration and the objective demonstration of suspicion, resentment, and pent-up hostility.

Paranoid expressions are prominent in many normal individuals. Revealed frequently in behavior that is individualistic and defensive, the essential paranoid quality is that the guilt for one's weakness or incapacity is referred to the environment and not to be assumed by the self. In everyday life we encounter the individual who feels himself quite blameless for the ills of the world. He blames them instead on the President, or Jews, or foreigners. The universality of paranoid tendency probably explains in part our propensity to organize into fraternal and patriotic organizations, professional societies, cooperatives, and labor unions. It is natural for all of us to feel exploited and to refer our personal inadequacies to agents other than ourselves. In so doing we are often righteous, for like the paranoic we are all of us logical.

As with other tendencies in normal behavior, so with paranoia: it is the extreme expressions which characterize maladjustment and which, when the individual's basic premises seem to most of us illogical, are considered psychotic. Paranoia is typically a solution characterized by rationalization which is logical and intelligent, meaningful and usually intelligible, but which is based on premises that are tenuous. We can see how similar the paranoid individual is to the obsessive-compulsive neurotic, who, believing that all milk bottles carry undulant fever, refused to drink any milk at all.

Typified by independent, personalized elaboration that is distinctly a departure from the usual, extreme paranoia is schizophrenic.

But paranoid schizophrenia, in contrast to other schizophrenic elaborations, is typically intellectualized and rational—rational indeed only in its own frame of reference—but devoid of the bizarre production and apparent intellectual deterioration of other extreme schizophrenic expressions.

Extreme paranoia is characterized by delusions of persecution and by hallucinations, chiefly auditory, that are accusatory. Often these hallucinatory experiences are accusations toward the patient of homosexuality. This coincidence of paranoia and homosexual factors suggested to Freud (42) the possibility that paranoia was characteristic primarily of repressed homosexuality. There are many facts that substantiate this concept. The paranoid individual usually reacts strongly to his own sex; his reaction is, to be sure, one of hate but it is definite, not neutral. Paranoid individuals are occasionally celibate, but more often they marry and divorce frequently, produce few children, and are often impotent or frigid; their marital adjustment is typically chaotic.

The history of the paranoid individual is frequently characterized by tentative (and often disastrous) excursions, during adolescence, in the direction of homosexual experimentation. The paranoid individual is found often to have been hostile in childhood to the father. On the basis of these observations and psychoanalytic studies of paranoid patients, Freud and other analysts concluded that paranoia was an eventuation of severe castration fear in early childhood.

Examination of the scoring of items of the Minnesota Inventory reveals that of 40 items that contribute toward a score for *paranoia*, only 14 of these score for this variable alone (or together with masculinity-femininity). These items are

Answered "True"

I have certainly had more than my share of things to worry about.
I believe I am being followed.
Someone has been trying to influence my mind.
Someone has control over my mind.
Someone has been trying to poison me.
Evil spirits possess me at times.
I feel uneasy indoors.
I think that I feel more intensely than most people do.[1]

Answered "False"

My father and mother often made me obey even when I thought that it was unreasonable.

[1] Contributes also toward score for masculinity-femininity.

Most people inwardly dislike putting themselves out to help other people.
I think nearly anyone would tell a lie to keep out of trouble.
The man who provides temptation by leaving valuable property unprotected is about as much to blame for its theft as the one who steals it.
I have no enemies who really wish to harm me.

On four items, *paranoia* is scored together with *psychopathic deviate:*

Answered "True"

Someone has it in for me.
I am sure I am being talked about.

Answered "False"

I have never been in trouble with the law.
Most people are honest chiefly through fear of being caught.

On two items, *paranoia* is scored together with *hysteria:*

Answered "False"

I think most people would lie to get ahead.
Most people will use somewhat unfair means to gain profit or an advantage rather than to lose it.

Five items contribute toward scores for both *paranoia* and *schizophrenia:*

Answered "True"

I believe I am a condemned person.
At times I hear so well it bothers me.
At one or more times in my life I felt that someone was making me do things by hypnotizing me.
I believe I am being plotted against.
People say insulting and vulgar things about me.

Together with both *schizophrenia* and *psychopathic deviate, paranoia* is scored on the following items (answered "True"):

No one seems to understand me.
If people had not had it in for me I would have been much more successful.
I am sure I get a raw deal from life.

With *psychasthenia,* and, on the second and third items also with *schizophrenia, paranoia* is scored on the following (answered "True"):

I am more sensitive than most other people.
Even when I am with people I feel lonely much of the time.
Once in a while I think of things too bad to talk about.

A single item contributes toward scores for *paranoia*, *schizophrenia*, and *hypochondriasis* (answered "False"):

I do not often notice my ears ringing or buzzing.

The fantasy of paranoid patients frequently reveals symbolic homosexuality. Such patients dream of aggressive attack directed toward themselves, often by means of knives, needles, etc.—symbols traditionally considered to be phallic. Often suggested as symbolic of the penis is the hypodermic needle. In the discussion of epilepsy we saw that in at least one instance genuine *grand-mal* convulsion was induced by the sight of a hypodermic needle. In another case, reported by Dunbar (4), psychosis with strong paranoid features was alleviated by psychoanalytic treatment, only to have diabetes appear in its place. But it was found in this case that satisfactory psychological adjustment could be achieved only when in the administration of insulin the hypodermic treatment was replaced by oral administration.

The following case, reported by Masserman and Balken (96), illustrates the manner in which paranoid features are revealed in the thematic apperception stories, not only in initial evasiveness, but in the intensity with which "an emotionally charged and highly significant response may break through."

. . . an obsessive-compulsive female patient with marked paranoid tendencies gave the following response to picture N7 during the initial period of her resistance to treatment:

"I don't even see what it is. It's a thumb or finger. Do I have to tell you something about it? I sure would like to help you out but I don't know. To me it's just a thumb and a drop of blood and that's all it is. . . . "

A week later, however, when some rapport with her had been gained, but even before her antagonistic behavior had changed on the ward, she gave, after a series of even longer and more elaborate phantasies, the following story in association to the same picture:

"One day while I was fixing dinner (this is going to be very short) I was quite excited at the thought of having guests and being a little behind schedule. In my frenzy to be all ready when the guests arrived, I cut the roast and accidentally slipped, thus cutting my thumb. I didn't even discover what I had done until a big drop of blood started oozing out. I called my husband and he bandaged it up for me. As a result, when I become nervous nowadays, and guests are expected, I don't try to cut the roast myself. I leave that for my husband to do. (Pages 83–84.)

Depression

The paranoid may be considered a protective, aggressive action against homosexual urges. The unconscious guilt for homosexual tendencies is seen to be projected onto others in the same way that the compulsive patient, in developing phobias, projects his fear. Guilt as a source of anxiety has been mentioned as important in the psychogenesis of other elaborations, such as schizophrenia, in which it is often associated with masturbatory conflicts. The most intense and characteristic reaction to guilt, wherein blame is neither projected nor distorted, is in *depression*, by which reaction the individual accepts blame personally. Since the full expiation for one's sins is to die, the extreme depressive reaction is often suicidal.

Similar in its self-direction to the epileptic's expression of hostility is the tendency for the depressed patient to injure himself as if in punishment. The tendency to self-injury may vary all the way from the neurotic to the intensely psychotic; it is in the latter that it is fully depressive and suicidal. We have seen that extratensive individuals seem often to utilize injury as a social solution—a way of rendering one's inadequacy socially acceptable. Such self-injury is not accompanied by the personal grief, however, that is a fundamental aspect of the depressed personality. The depressive's motivation is in the direction of self-destruction and death as a final absolution for sin and not toward self-mutilation for show purposes.

Particularly in our culture it is frequently the case that guilt is associated with the awareness and expression of sexuality. In severe depression the patient frequently reveals the significance of sexual conflicts, not only regarding masturbation and homosexual urges but heterosexual expression as well. Again, it is often apparent that guilt is associated not so much with regrettable *expression* of sexuality as with urges toward expression that are unacceptable. Frequently these urges toward expression are only partly understood, and they may be so distorted in the individual's consciousness that they appear quite unrelated to sexuality. Often the patient's guilt is associated with hostile impulses toward others. Depressed reactions frequently are precipitated by the death of a parent or a loved one, a death for which the patient feels himself in some way to blame. Such guilt reactions were common during the war. The soldier argued with himself that if his aim had been surer or his courage had been greater he could have averted the death of his buddy, and he

felt as the result that he himself deserved no fate better than death.

It is apparent that anxiety features are frequently common in depression. By comparison with anxiety state, however, the patient's uncertainty is not free-floating; it is associated specifically with the systematic, delusional acceptance of personal guilt.

Frequently so intense is the patient's concentration on the problem of his personal guilt that a marked withdrawal from the everyday environment may be observed, even to the extent that he refuses nourishment and requires full personal care. In such extremity his preoccupation is comparable in many respects to the withdrawal of the catatonic schizophrenic. In contrast to the typically catatonic picture, however, are the very definite mood characteristics, unmistakably those of intense sorrow and grief. Despite the fact that he may express himself in autistic outbursts, the typical catatonic by comparison seems generally unemotional. It is because of the particular significance of mood factors that, in traditional psychopathology, depression (as well as manic activity) is called an "affective" disorder.

In an examination of the history of patients prior to the onset of agitated depression, Titley (140) found a pattern of traits identical with that found for patients who later developed involutional melancholia.

A composite picture of the personality in cases of agitated depression may now be drawn. The scope is generally limited to the home and/or work, with occasional admission of the church.

During childhood the person is shy, timid and retiring and is accounted a model for others. Adolescence finds him continuing in the same vein and little interested in the usual pursuits of that age, generally preferring more serious interests, of an adult nature. Already a propensity for championing the "proper" course or the "right thing" is apparent. Except when his code is threatened, however, he is reticent and does not reveal any special depth of feeling, even though his associates begin to recognize sensitivity of a type not aroused by or susceptible to gibes. If late adolescence finds him in college, he adjusts to this major change in environment with great difficulty, and often with much anxiety.

The end of schooling finds him a worker whom employers appreciate. Earnest, prompt, diligent, unvaryingly honest and dependably exact, he is as frugal with his employer's time and money as with his own. Marriage tends to be delayed on various pretenses and is entered into in a spirit of conformity to expected behavior rather than in response to any great emotional urge. Children are avoided on one pretext or another, or if

these excuses fail their arrival gives rise to anxious forebodings. No emotional bonds are established between him and his marital partner or children, but respect is demanded; their conduct is dictated by his code and rigidly, without allowance for human frailty.

Middle age finds him a respected, and at times feared, but little loved member of his home and community. In business he is valued by his superiors because of his assiduity, though at times his stubborn adherence to established custom is exasperating even to them. His subordinates, though bound to admire his tenets, are held in awe by his lack of humor and the firm manner in which he holds them to detail. The commonly accepted recreations are foreign to him. If any concession is made in this sphere it is indulged in a businesslike fashion and without any sense of play. Personal finances are a matter for hesitant caution, and only the most conservative investments are made. This propensity is carried to the extremes of frugality, and even to penury. Friendships are conspicuous by their absence, or generally limited to a few, who must accept his reticence, taciturnity and frugality if they are to be so rated. His health, or that of his family in certain instances, is a matter for some preoccupation. The respect of the community is his, but no man feels that he knows him. His existence is so subject to routine that it is often facetiously said that clocks can be set by the punctuality with which he does things.

The feminine counterpart is even more narrow in her views, but is likewise capable in her sphere. Any disarray in her home is upsetting. Everything is performed in a meticulous and inflexible manner, and any deviation arouses anxiety. Marriage is a matter of convenience, and little emotion enters the pact. Frigidity, often accompanied by actual distaste for sexual union, is the rule. While her ability as manager of her home is acknowledged, all who come in contact with her recognize her aloofness.

Combination of these factors of personality with superior intelligence results usually in material achievement above the average. The person of low average intelligence, however, will be found filling a drudgelike position, having minutiae as his great responsibility and reassuring himself with the thought that he is indispensable because of his exactness, wherein he is most pedantic. (Pages 340–341.)

In the Minnesota Inventory, 60 items contribute toward a score for *depression*. Of these, 37 contribute also toward scores for other Minnesota variables. The remaining 23 items contribute only toward *depression* (or masculinity-femininity). These are

Answered "True"

I do not have spells of hay fever or asthma.
I am easily awakened by noise.
Criticism or scolding hurts me terribly.

I brood a great deal.
I certainly feel useless at times.

Answered "False"

I believe I am no more nervous than most others.
I have never had a fit or convulsion.
My judgment is better than it ever was.
Sometimes, when embarrassed, I break out in a sweat which annoys me greatly.
I like to flirt.
I go to church almost every week.
I believe in the second coming of Christ.
Everything is turning out just like the prophets of the Bible said it would.
I am a good mixer.
I enjoy many different kinds of play and recreation.
I usually feel that life is worth while.
At times I am full of energy.
At times I feel like smashing things.
At times I feel like picking a fist fight with someone.
When I leave home I do not worry about whether the door is locked and the windows closed.
I do not worry about catching diseases.
I sometimes tease animals.[1]
Once in a while I laugh at a dirty joke.

Several items are scored for *depression* and for *psychopathic deviate:*

1. For these alone (answered "False"):

I have periods in which I feel unusually cheerful without any special reason.
Sometimes without any reason or even when things are going wrong I feel excitedly happy, "on top of the world."

2. With *hypochondriasis* (answered "False"):

I am neither gaining nor losing weight.

3. With *psychasthenia* (answered "False"):

I wish I could be as happy as others seem to be.

4. With *hysteria*, *psychasthenia*, and *schizophrenia* (answered "True"):

I find it hard to keep my mind on a task or job.

and (answered "False"):

My daily life is full of things that keep me interested.

With the neurotic variables *hysteria* and *hypochondriasis*, there is considerable overlapping on the part of *depression.* Thus, on 10

[1] Scores also for masculinity-femininity.

items, scores for *hysteria* or *hypochondriasis*, or both, are made together with a score for *depression*. These are

1. For these alone:

Answered "True"

I have never vomited blood or coughed up blood ("False" for *hysteria*).
I am troubled by attacks of nausea and vomiting.
My sleep is fitful and disturbed.

Answered "False"

I have never felt better in my life than I do now.
At times I feel like swearing.
I am very seldom troubled by constipation.
During the past few years I have been well most of the time.
I am in just as good physical health as most of my friends.
I have a good appetite.
I am about as able to work as I ever was.
It takes a lot of argument to convince most people of the truth.[1]

2. With *paranoia* (answered "False"):

I am happy most of the time.

3. *Hypochondriasis* and with *psychasthenia* (answered "True"):

I feel weak all over much of the time.

Thus, on a large block of items, *depression* is scored together with the variables considered to be neurotic tendencies. That there is also for *depression* a wide overlap with the more psychotic variables of *schizophrenia*, *paranoia*, and even *psychasthenia* is suggested by the co-scorings already mentioned and by the following:

1. *Depression* and *schizophrenia* alone:

Answered "True"

I prefer to pass by school friends, or people I know but have not seen for a long time, unless they speak to me first.
I have difficulty in starting to do things.
I don't seem to care what happens to me.

Answered "False"

I dream frequently about things that are best kept to myself. ("True" for *schizophrenia*.)

2. *Depression* and both *schizophrenia* and *psychasthenia:*

[1] Scores also for masculinity-femininity.

Answered "True"

I cannot understand what I read as well as I used to.
I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going."
I am afraid of losing my mind.

Answered "False"

My memory seems to be all right.

3. With *psychasthenia* alone:

Answered "True"

I certainly am lacking in self-confidence.

Answered "False"

I seldom worry about my health.
I seem to be about as capable and smart as most others around me.
Most nights I go to sleep without thoughts or ideas bothering me.

In addition to the items already mentioned, one item scores for both *depression* and *paranoia:*

Answered "True"

I cry easily.

In stories produced in response to the thematic apperception pictures, Masserman and Balken (96) found that fantasies were "quite characteristically retarded, halting and fragmentary, deeply colored with ideas of guilt and self-depreciation and more or less hopelessly nihilistic." One of their patients, a young man for whom no previous evidence of suicidal intent had been discovered, but who subsequently made an actual suicidal attempt, told the following story in response to picture M 14:

This man—this lad—has been unsuccessful for some time. He had had no job, no money, no friends, quite alone most of the time. He had tried many ways out, forcing himself to mix with people. This one day it's quite hard for him, it's hit him awfully hard—his remorse and discouragement. He sees this sharp instrument. He argues with himself for some time. Finally, he goes into this small clothes closet and he stabs himself with this blunt instrument. He's lying there doubled up in pain and realizes the folly of his act. Remorse over lack of work, lack of friends, being alone most of the time, having to be dependent on his folks. I seem to be putting myself into these stories. (Pages 84–85.)

In the Rorschach responses depression is revealed to some extent in the use of restrained and inanimate movement together with animal movement but particularly in the shading responses that utilize the surface qualities, notably the black color of the achromatic blots. Piotrowski (108) feels that responses in which some dysphoric mood quality is present (examples, "gloomy night," "dark clouds presaging a storm," "a nightmare," "despair," "hideous monster," "black butterfly," "the shadow of a prehistoric monster") may be interpreted "as signs of anxiety, of uncertainty, of a feeling of being exposed to danger, of doubt concerning the most suitable method of controlling a potentially hostile environment . . . [they] are indications of a real tendency to intermittent depressive moods which are partly welcome and partly unwelcome."

Manic Activity

Inner elaboration in psychotic depression is characterized by the focus of the total personality on the single delusion of personal guilt. Socially the depressive reaction appears to be a withdrawal, a reduction of motor activity and emotional expression. Response to stimulation from the outside is slowed and lethargic. The individual shows little flexibility of attention. Quite the opposite reaction is that known as *manic activity*, an expression of the personality also considered to be associated with feelings of personal guilt but in which the prominent feature—exaggerated social expression—is an effort to compensate for guilt. The manic patient seeks through multiple activity to find distraction from his personal problem. Thus, while depression is a withdrawal, manic activity is an extroverted participation. The attention of the manic patient shifts easily from topic to topic. He is emotionally expressive, often with violence. Like the depressed patient he is often delusional and hallucinated, but his ideas are grandiose and self-complimentary rather than self-deprecating. The depressive's intense feeling of inadequacy is replaced in manic activity by an exaggerated sense of competence and power.

In its less exaggerated form, referred to as *hypomania*, we find within the range of normal adjustment evidence of manic activity—in the carefree manner in which some persons attack their daily problems, move quickly from one task to another, maintain for long periods a level of active participation that seems to serve as a sustaining force. Such behavior occurs frequently in an individual

whom we suspect actually of feelings of inferiority. Participation itself seems in such cases to serve in the face of threat of failure as a constant reassurance of competence.

The Minnesota Inventory provides 46 items that score for *hypomania.* Of these 20 score for *hypomania* alone:

Answered "True"

A person should try to understand his dreams and be guided by or take warning from them.

Some of my family have habits that bother and annoy me very much.[1]

Often I have had to take orders from someone who did not know as much as I did.

I have been inspired to a program of life based on duty which I have since carefully followed.

When I was a child I belonged to a crowd or gang that tried to stick together through thick and thin.

If several people find themselves in trouble, the best thing for them to do is to agree upon a story and stick to it.

I don't blame anyone for trying to grab everything he can get in this world.

At times I have been so entertained by the cleverness of a crook that I have hoped he would get by with it.

It wouldn't make me nervous if any members of my family got into trouble with the law.

When I get bored I like to stir up some excitement.

I never worry about my looks.

It is not hard for me to ask help from friends even though I cannot return the favor.

I have met problems so full of possibilities that I have been unable to make up my mind about them.

At times I feel that I can make up my mind with unusually great ease.

I am an important person

Answered "False"

It makes me impatient to have someone ask my advice or otherwise interrupt me when I am working on something important.

I believe women ought to have as much sexual freedom as men.

I am afraid when I look down from a high place.

My table manners are not quite as good at home as when I am out in company.[1]

Sometimes when I am not feeling well I am cross.

Hypomania is scored together with *psychopathic deviate* on the following:

1 Witn *psychopathic deviate* alone (answered "True"):

At times my thoughts have raced ahead faster than I could speak them.[1]

Answered "False" by *psychopathic deviate:*

It makes me uncomfortable to put on a stunt at a party even when others are doing the same sort of things.

2. Together with *hysteria* (answered "False"):

When in a group of people I have trouble finding the right things to talk about.
I find it hard to make talk when I meet new people.
I am always disgusted with the law when a criminal is freed through the arguments of a smart lawyer.

3. With *paranoia* (answered "True"):

I know who is responsible for most of my trouble.

4. With *schizophrenia* (answered "True"):

At times I have very much wanted to leave home.

There is very little overlapping between *hypomania* and the neurotic variables *hysteria* and *hypochondriasis;* beside the three items above, three other hypomanic items score also for *hysteria.*

1. For *hypomania* ("True") and *hysteria* ("False"):

I drink an unusually large amount of water every day.

2. For *hypomania* ("True") and *hysteria* and *paranoia* ("False"):

Some people are so bossy that I feel like doing the opposite of what they request even though I know they are right.

3. For *hypomania, hysteria, psychasthenia,* and *schizophrenia* (answered "True"):

I have periods of such great restlessness that I cannot sit long in a chair.

It is apparent that of the items that score for both *hypomania* and *hysteria,* several contribute in an opposite way. *Hypomania* overlaps most with variables of the *Shizophrenia-paranoia-psychasthenia* pole. Thus, six items present scores for *hypomania* and *schizophrenia:*

1. Alone (answered "True"):

I have had periods in which I carried on activities without knowing later what I had been doing.
I have had attacks in which I could not control my movement or speech but in which I knew what was going on around me.
I have had blank spells in which my activities were interrupted and I did not know what was going on around me.
At times I have a strong urge to do something harmful or shocking.
My people treat me more like a child than a grown up.

(Answered "False"):

My speech is the same as always (not faster or slower or slurring; no hoarseness).

2. With *paranoia* or *psychasthenia* or both on the following (answered "True"):

I feel that I have often been punished without cause.
Once a week or oftener I become very excited.
At times I have fits of laughing and crying that I cannot control.

Hypomania and *paranoia* alone are scored on the following items:

Answered "True"

Something exciting will always pull me out of it when I am feeling low. ("False" for paranoia.)

Answered "False"

I have never done anything dangerous for the thrill of it.

The frequently suggested antithesis of *hypomania* and *depression* is supported by the presence in the Minnesota Inventory of four items that score oppositely for these variables (answered "True" for *hypomania*, "False" for *depression*):

I sweat very easily even on cool days.

I have at times stood in the way of people who were trying to do something, not because it amounted to much but because of the principle of the thing.

I do not blame a person for taking advantage of someone who lays himself open to it.

I sometimes keep on at a thing until others lose their patience with me.

A single item is scored similarly for *hypomania* and *depression* (answered "True"):

I work under a great deal of tension.

Depression and manic activity are sometimes found to occur at different times in the same individual, sometimes alternating in such a way that the patient suffers periods of "ups and downs." For this reason the psychotic expressions of these so-called "affective" reactions was given the name "manic-depressive psychosis" by Kraepelin (83), who considered this to be a disease entirely different from schizophrenia. The chief difference between the two syndromes was the observation that factors of mood were pathognomic in the case of the manic-depressive psychosis, while in typical schizophrenia emotional expression was considered flat and dulled.

In recent years there has developed a tendency to consider that between the manic-depressive psychosis and schizophrenia there is so much overlapping that the difference might be illusory; hence, the term "schizo-affective psychoses" has been used instead.

In childhood the counterpart of manic behavior is revealed in what has been described as *hyperactivity*. Russell (122) has suggested that exaggerated activity in children is both "a mode of self-expression" and a "symptom, a sign of deep-seated needs." As we shall see in the following chapter, in children hyperactivity often follows brain

disease known as encephalitis, but, as Russell points out, it may follow also birth injury. However, organic pathology need not necessarily be involved at all. An illustrative case of manic or hyperactivity in childhood is borrowed from Russell's paper:

The patient was referred to the clinic at the age of 6 years. His mother wanted him placed in a foster home or an institution, because of his extreme hyperactivity and destructive behavior. He refused to stay in school, bullied other children, was hostile toward his younger sister, had enuresis and soiled himself. He was beyond the control of either parent and responded to none of the discipline they employed, which included beating, bribing and removal of privileges. Often they tied him in his chair. The mother stated that the only place they could live with him was in the country, where he might run wild. In her estimation he was bad and incorrigible. The physical examination revealed nothing abnormal except marked restlessness, impulsiveness and underdevelopment. The psychologic examination indicated that the boy had normal intelligence. A study of the family situation revealed that the mother was extremely unhappy in her marriage and that the supposed father was alcoholic. It was later learned that he was not the real father. The child was illegitimate, the mother having become pregnant during a period when she was separated from her husband. The father always punished the mother through the child, who could well be described as rejected and a symbol of something which both parents wished to remove from their lives. The boy's behavior became so disturbing that it was necessary to remove him from his home. He was placed in a children's convalescent home, and although many observers were skeptical about his adjustment to the orderly discipline of such a setting, he lost all his hyperactivity and destructive behavior and was no longer a "problem" child. In the convalescent home he was accepted and understood and was not subject to his parents' destructive attitudes. (Page 99.)

Such manic behavior, destructive or otherwise, is essentially attention-getting behavior, motivated toward ego satisfaction or through the need for love and security. In adults, while the motor aspects of this exaggerated activity may give way to more conventional methods of gaining attention, the motivational psychology is similar and seems to stem from a basic sense of personal inadequacy.

A lifelong tendency to utilize a hyperactive, manic solution to frustration is illustrated in the case of Tony.

Following a blast in his vicinity on Okinawa about May 26, 1945, Tony was evacuated on June 4, 1945. He was an assistant cook in the Marine

Corps, with rating of corporal. The first thing he realized following the explosion was that he was lying on a stretcher, and parts of human bodies rested on him; he coughed persistently following this. A patient at Pearl Harbor from June 22 until July 8, Tony was noted to weep frequently, to exhibit a marked startle pattern, to eat poorly, and to have nightmares and persistent insomnia. Particularly vivid was the memory of parts of human beings near him. He was concerned also, however, about domestic problems. Given "modified group psychotherapy," he was finally evacuated on July 8, 1945, to the United States.

History given entirely by him revealed that Tony was the second of four children. His mother died when he was born ("of sugar diabetes and hysterical"); his father soon married a sister of the mother. The stepmother and father were now living; the former was described as having been treated for a nervous breakdown. The father, an Italian-American in the ladies garment business, was described also as nervous, as having suffered a nervous breakdown, and a "leaky heart."

At two Tony suffered spinal meningitis; this was followed by strabismus and malocclusion (?). As a child he was very restless, had frequent headaches, could not tolerate heat, nor take restrictions. Very emotional and impulsive, he could not be pushed around. A problem child at home and in school, he was always in mischief and "couldn't stick to anything." He was enuretic until ten, and had frequent nightmares. At twelve began a series of fainting spells, which disappeared by the time he was twenty. These he described as "seeing needles, as if somebody was going to jab me." At fifteen he himself had a nervous breakdown explained by him as due to the feeling that "Dad was sick . . . I just couldn't control myself. Dad jumped on me a lot."

In school, Tony's work apparently was, despite his mischief, fair. However, at fourteen, he quit the eighth grade and began working. Off and on he helped his father in the dress business, which he now claimed was the "only thing I know." But he worked also for a grocery store and for a short time as a welder. He denied any venereal history or any arrests. At twenty-one he married; the couple has since had one child. Marriage apparently was fairly satisfactory. However, his wife was rejected by Tony's family because "she comes from a lower class of people." Tony himself complained of "mother-in-law trouble," referring to his wife's mother as "that old stinker."

In December 1942, at 24, Tony volunteered, on an impulse, for the Marine Corps. During the training period in the United States, he was observed to be impulsive and restless. He had three courts-martial, one of which was for going AWOL 29 days. This breach he explained as due to a need to earn extra money for his domestic bills. It is interesting that he returned one day short of earning status as a deserter, which would have involved grave penalties. Tony was referred for psychiatric con-

sultation, and recommended because of his restlessness and domestic worry for limited duty in the United States. He spent altogether 27 months in the United States. However, hearing that his older brother was killed at Guam, he conceived immediately the idea that he should avenge his brother's death by killing Japs, and he managed to get assigned for overseas duty. For 25 days on Okinawa he had his chance. He killed Japs, even children. As a cook, however, his combat activity was limited largely to burying the dead, picking up bodies, etc. This work was distinctly unpleasant to him, and his restlessness and anxiety mounted. In the catastrophic situation mentioned above—the blast—he finally broke down completely.

So much for history. At the final hospital in the United States, physical examination revealed an individual of good general appearance, height 5 feet 4 inches, weight 130 pounds. Dental condition was very poor; he required much prosthetic work. Neurological examination was negative.

On the ward he was sociable and active, noisy, facetious, and demanded attention. However, despite this, he was a great favorite. Because of his impulsiveness he easily got into minor difficulties. In psychiatric interview he was observed to depart markedly from this role of aggressive but acceptable social participation. Here he was emphatic in his attitude toward combat. He reported that he had gone overseas solely to avenge his brother's death; having done this, he now wanted to go home—he could stand no more combat. Discussing battle experiences he verged on tears. He confessed to fears particularly of the sight of blood and of mice. Discussing his domestic problems he was full of purposeful ambition to relieve his father of the full responsibility of his business. His resentment toward the service was extreme and emotional; his desire for civilian life was calm and considered.

Psychological examination revealed many interesting features. His initial response to the examination was one of superficial irritation and bored compliance, but as the interviews progressed he became easily cooperative. His performance with the Bellevue verbal tests yielded an I.Q. of 105. But, despite good verbal fluency and rote memory, his speech had a high content of nonsense, confabulation, and neologism, amounting almost to a "flight of ideas." Here are some examples:

Q. What does the heart do?
A. It *penetrates* the blood—when you get excited it beats more.

Q. Why should people pay taxes?
A. To keep democracy going, upkeep, town needs it, *repairment*, and so forth.

Q. If you were lost in the woods in the daytime, how would you go about finding your way out?
A. Sun, compass, sets at night usually in the southwest.

Q. Why does the state require people to get a license in order to be married?
A. Records of who's who,—most of the popularity—everybody would get married 4, 5, 6 times, which they're doing now, anyway.

Q. Why are people who are born deaf usually unable to talk?
A. That's up to medical science.

Q. Eight men can finish a job in six days. How many men will be needed to finish it in half a day?
A. If it takes 8 men for 6 days, you double, you *three-times* it.

On the nonverbal scales of the Bellevue, performance was very poor particularly with the Block Designs, in which he achieved an I.Q. of 59. With an I.Q. of 78 for the total nonverbal, Wechsler's picture of the typical organic case was strongly suggested; but this was somewhat negated by the excellent score for digits (I.Q. 121).

The patient's Rorschach responses were as follows:

I. (8″)	Looks to me like an eagle or something—an eagle or butterfly of some sort (because of wings and legs above-W).
II. (8″)	Some kind of animal. (A crab, crawling.)
III. (20″)	Well, it's a face of a cat (furry) or something like that ("except for those side blots—the blots over here give you an *off the track*").
IV. (10″)	Well, they're all different kind of animals (later decides on a furry racoon).
V. (10″)	Is another fly of some sort? (in flight—"like a shell, can't say grasshopper, but the rest of it comes out").
VI. (20″)	Oh my God! (pause) An animal (crawling insect).
VII. (R at 20″)	Just a blot, that's all. ("Just an ordinary blot . . . or could be the sketch of a cat," mean furry.)
VIII. (10″)	Some kind of land crab or something? (W) Are these mice up here? ("look lousey enough to look like them") (Turns sideways) Oh, I see how they work now.
IX. (15″)	You got me . . . can see fingers above (blot upside down) A couple of—look like reindeer heads—(Sideways) Got a (man's) head on one side, and you got a (furry dog's) head on the top (both these latter in pink).

X. (12″) You got two crabs, the blue ones are crabs. That's all I can say (on inquiry, added "These two" inner blue—"I don't know if they look like men or not . . . Got a wishing bone here" inner brown).

This Rorschach is notable in several respects. The frequent use of animal figures and particularly in movement suggest the importance of strong, infantile impulses. On the other hand, the increased productivity on the last three, colored cards and the unusually frequent use of surface texture suggest a personality highly sensitive and responsive to external pressure and fairly reliant on superficial demonstration of tact and good taste as a means of social adjustment. It was suggested that, left to his own devices, the patient was aggressive and childlike and, under social pressure, highly stimulated to "give out" irrespective of the quality of response.

In response to the pictures of the Thematic Apperception Test, the patient told the following stories:

Picture No.

3 Well, in the first place, there's a gun on the deck, and it would probably be a woman . . . she's sorry, crying. . . .

4 (laughs) He's trying to give her the go-by . . . she's pleading with him or something—call it love, or infatuation (Will she succeed?) I don't know. . . . (explosively) I never trust women, that's all. . . .

6 Well—bad news! Either he's going away or he must have told her something—something about her boy or something. . . .

7 Well, it probably—that probably would be his dad trying to tell him something or it could be the district attorney giving advice . . . seems sorry for what he done.

9 Well, a bunch of hoboes just taking life easy . . . not worried about tomorrow.

12 Well, either he's getting . . . or she . . . he's been trying to attempt to kill her or give her a pardon—saying his last prayers. . . .

13 He's killed her and he's sorry now . . . that he had a good time or something. . . .

14 Well, feeling lonely, moody, just looking outside at the clouds, wondering, thinking.

17 Oh, he's sneaking down from somewhere—sneaking out. . . .

18 Well, he's being molested and being picked up . . . he's resisting arrest . . . or something like that . . . (What for?) Probably in a brawl, in fight, or something like that, drunk. . . .

These stories reveal the basic aggression and impulsiveness at a fairly infantile level that is suggested by the Rorschach. Note the ease with

which the patient identifies himself with the male figure, ignoring the female figures almost completely.

On the Minnesota Inventory, the patient revealed his uncertainty by classifying 51 (of the short series of scorable items) as Cannot Say. A standard score of 80 on the F scale raises slightly the question of validity for the remaining scores. These formed an interesting pattern, with *femininity* and the neurotic variables, *hysteria* and *hypochondriasis*, quite within the normal range, and with exaggerations uniformly for *psychopathic deviate* and for the more psychotic variables of *psychasthenia* (81), *paranoia* (70), *depression* (70), *schizophrenia* (84), and *hypomania* (75).

Tony's case is highly interesting from several viewpoints. The test performances together with the history of impulsive, hyperactive, attention-getting behavior following spinal meningitis as an infant suggest the real possibility of brain disease at that point which served as a definite frustration. His need to fortify his ego is apparent in this exaggerated behavior. His adjustment to service life prior to combat was consistent with his adjustment to school, to his work, and to his marriage. To achieve his ends he typically exercised charm and tact, but when these were unsuccessful, he resisted, then rebelled, taking matters in his own hands. Profoundly stirred to action by the news of his brother's death in battle, impulsively and persuasively he managed to get an overseas assignment despite his classification as a behavioral risk. His Rorschach performance—that of the impulsive, immature psychopatic personality—confirms his history to this point. During 25 days of intense combat the patient's anxiety under extremely morbid conditions increased markedly, reaching a climax in the explosion mentioned above, a final insult to his already shaky ego. The following contraction of his entire self, consequent self-doubt, and anxiety were expressed clearly in his behavior. Anxious, as revealed in nightmares and insomnia, aware of his inadequacy in his open weeping, the old, compensatory solution emerged anew: after a brief period of confusion and disorientation, he became more than ever the self-assured, hyperactive, friendly and aggressive "big shot," anxious to dispel immediately any doubts about his adequacy for practically anything. Yet, his conviction that home rather than further duty was the answer betrayed his real judgment in the matter; he was incapacitated for further combat duty.

In the progression from neurosis to psychosis, from the solutions socially oriented to those elaborated within, we have emphasized the increasing significance of elaborative factors that individualize the personality, rendering it increasingly different and queer, and hence outwardly providing evidence of departure from (usual) reality. Not only do we find that manic and depressive reactions are often

very similar to schizophrenia in their elaborations, but we have seen that to a lesser extent epilepsy and even the obsessive-compulsive reactions may embrace elaborative features that sometimes are so personalized as to be considered psychotic.

In the next section we shall discuss factors other than psychological which may alter the personality pattern and which have been considered to account, at least in part, for syndromes considered organic.

CHAPTER XIII

PRECIPITATION AND PREDISPOSITION

The Situation

We have now discussed at least briefly most of the solutions that the individual develops as a means of reducing the anxiety attendant upon frustration of basic needs. Most people when frustrated work out for themselves solutions that are adequate and do not require clinical attention. These successful solutions may be termed "readjustment." Of the remaining solutions—those that are clinically significant because they are inadequate—all could be placed along the continuum from hysteria to schizophrenia.

It is important now for us to consider in some detail the nature of frustrations with which inadequate solutions are often associated. In what degree is the nature of the solution a function of the situation in which it appears to be precipitated? One encounters in the literature of psychopathology phrases such as "war neurosis," or "shell shock," or "reactive depression," or "traumatic psychosis," or "postencephalitis," used in a manner that suggests that behavioral symptomatology is determined at least to some extent by the specific nature of the situation or misfortune that befell the individual. The reader needs only to refer to the Appendix, the psychiatric nomenclature, to see that in common clinical practice a number of syndromes are classified primarily according to what is believed to be the precipitating agent, or cause. It is the purpose of this chapter to consider this large group of diseases in the light of the hysteria-schizophrenia continuum we have already suggested.

Situations in Normal Development Found Frequently to Be Particularly Frustrating

In earlier discussion we saw that neurotic and psychotic solutions often seem to emerge as the extrapolations of patterns of reaction to frustrations early in life, particularly those in association with the young child's needs for love and security. As a general proposition, then, it can be suggested that when infancy and childhood are char-

acterized by rejection and insecurity these serve for any child as major sources of frustration. Moreover, the failure to derive security early in childhood seems often to determine inadequate patterns of satisfaction (such as overdependence on the mother, withdrawal from difficult situations, temper tantrums), which as lifelong modes of solution become fixed and appear in adulthood as neurotic or psychotic incapacitations. Apparently characteristic of the individual's mode of adjustment throughout life, these early determined patterns sometimes seem constitutional, as if inherited, an impression reinforced by the observation of similarity between the pattern of the child and those of his parents and relatives.

Fetal Period and Birth

At no period in life does the child derive more complete security than as a fetus within the mother's uterus. Indeed, certain interpretations of behavioral phenomena in psychosis, based on psychoanalytic theory, look upon activities such as the catatonic stupor and the contractive nature of the epileptic convulsion as attempts symbolically to return to the perfection of intra-uterine life. Whatever the validity of these hypotheses, even during the fetal period the infant is probably subject to stress. As the origin for a number of physiological conditions found at birth, such as hyperthyroidism and malnutrition, the possibility of endocrine or other influence from the mother's blood stream has been suggested. We know, further, that the infant during the fetal period may acquire diseases such as syphilis; it may develop allergic sensitivities. While we know little about the degree to which the fetus' behavior may be influenced similarly and permanently, we do know that the fetus is responsive to stimulation. In the later months of pregnancy mothers report variation in fetal activity in association with their own daily pattern of activity and an increase of fetal activity under conditions in which they themselves experience emotional tension. Experimental studies have shown that following the mother's smoking and following vibratory stimulation over the mother's abdomen the fetal heart rate may become accelerated. Such studies have not progressed to the extent of showing that the child may be conditioned during the fetal period, but they do reveal that the intra-uterine existence is not a perfect isolation.

That the normal period of fetal development—about ten lunar months—is important in providing the child with a good start of

security is revealed by the disastrous sequelae of its early termination. The complications following premature birth may be referred at least in part to the sudden termination of a necessary protective environment, the violent interruption of a readying process by means of which the child matures sufficiently to meet the demands of the postnatal situation. Usually delivery of the child before six months is fatal; as the full term is approached, after about six months, the child's stability in the face of the experience of birth is steadily enhanced. For any child a severe trial—birth represents a situation in which he must exercise full capacity for readjustment. That the sudden necessity to adapt to the postnatal environment is severely frustrating is represented, of course, in the radical procedures often required to induce breathing in the child.

Not only is birth a sudden challenge to the infant's capacity for adjustment, but the process itself often reduces his capacity. We have no way of knowing the frequency with which the child's brain is damaged in the birth process; the cases in which motor function is disrupted, as evidenced in postnatal paralysis (Little's disease), are relatively obvious. The impairment of intellectual function by the simple accident of birth injury is a matter requiring subtle evaluation. As we saw in Chap. VII, intellectual impairment following brain damage early in life, by comparison with later injury, tends to be generalized rather than specific for given functions. For this reason, it may be that many cases of congenital mental deficiency are reflections of brain injury sustained at birth. Particularly where intellectual impairment is associated with motor impairment is it suggested that the brain may have been damaged. Certain facts regarding the nature of the delivery are also of possible corroborative significance: the unusual speed of delivery (or its protraction), the position of the baby's head, passage through the birth canal with relation to other events in the delivery process, the use of instruments to facilitate delivery, etc. Sometimes the inference of severity can be made from evidence of circulatory disruption (cyanosis) in the baby. Again, the baby's head, which normally reveals some shaping following delivery, may also reveal marks of other specific areas of compression.

Childhood and Adolescence

Much has been made throughout this book of the frustrating situations critical in psychosexual development; we need not elaborate

on this subject here. Crises in the child's growing awareness of sexuality often occur because of parental failure to take into account the child's ignorance on the one hand and his curiosity on the other. Parental attitudes of evasiveness or prudishness or condemnation are often severely frustrating to the child, particularly when his questions regarding sex are considered less proper than others he may ask.

Many children are frustrated by equivocal affection from parents and others in the home. The child suffers if he cannot know where he stands. The parent who is intensely demonstrative at one time and thoughtless at another is essentially a rejecting parent, and the child is insecure.

One sees frequently the eventual frustration of the child or adolescent who has maintained a too close emotional dependence on the parents or the home. In such cases, radical changes such as the beginning of school or the first trip away from home may be particularly frustrating, not so much because of the nature of the new environment as because of inadequate training for self-reliance. Particularly frustrating to the growing child is the parent's failure to respect his emerging individuality and need of privacy. As many writers have pointed out, the period of adolescence is one of considerable isolation and loneliness, a period in which the individual comes to know himself and his potentialities. To tolerate the adolescent's vagaries, to recognize his success, to encourage his interests, all in the hope of ensuring independence at maturity—these are the tasks that confront all parents. To fail in these is to foster frustration.

The sexual conflicts of adolescence, while eventuations in part of early psychosexual development, are also related to immediate frustrations of expression. It is during adolescence that the intellectualized attitudes toward sexual expression become gradually prominent, and in this process the ideologies of health and of morality and of religion are often associated psychologically with sexual guilt and the need to dispel anxiety. It is important to recall that the schizophrenic psychosis, which so often involves these ideologies in association with masturbatory or homosexual preoccupations, was first named *dementia praecox* because it was considered to appear most frequently during adolescence. Influences that foster the association of sexuality with guilt are particularly frustrating to the adolescent. Initial sexual experiences are always of significance

as possible frustration. Frequently these experiences take place in sordid surroundings; often they occur as an unforeseen development. They may be intensely shocking, and they may be followed by regret and shame, so intense as to color later expression of healthy sexuality.

Adult Life

Frequently frustrating to adults are situations that lower prestige and thus insult the ego: financial failure, the loss of a job or the inability to get one—situations usually of greater potentiality for men than women, perhaps because men traditionally are more often expected to meet them successfully.

In her role as childbearer the woman faces many frustrations that confront men only secondarily. Very often it is the woman's responsibility to prevent conception, a problem involving ambivalent attitudes and often guilt in its frequent religious context. For all women pregnancy represents a radical situation, a change of the essential personality; while for many women the period may be a satisfying experience of fulfillment, for others it may be so intolerable as to provoke resentment and antagonism and deliberate abortion. Undoubtedly the anticipation of childbirth is an important factor in the anxiety of pregnancy. The actual experience of childbirth occurs as a profound shock to some women and may be followed by solutions of intense neurotic or psychotic coloring. In older psychopathology the specificity with which childbirth was observed to be followed by psychotic behavior led to the use of the term *puerperal psychosis*. The tasks of motherhood, particularly that of breast feeding, often act as frustrations.

In Chap. IX we discussed in some detail the frustrations associated with unsatisfactory sexual intercourse. These are important, of course, in the cases of both male and female.

The loss of sexual function, not necessarily paralleled by diminishing sexual drive, seems to serve in some cases as a special frustration, particularly to women. In men, the development of impotence sometimes seems to assume the significance of proof of the loss of manhood (aggressive masculinity, success). In women, the cessation of menstruation is usually accompanied by at least mild depression and irritability; in some cases this reaction may be exaggerated and may approximate severe, agitated depression characterized by suicidal tendency. This association of agitated depres-

sion with the menopause explains the use of the term *involutional melancholia*. The greater frequency with which this reaction appears in women than in men may suggest that the loss of sexual function is to women a greater frustration. Certainly the cessation of menstruation, like its onset, is a forceful reminder of the fundamental pervasive physiological change that it represents and is a more convincing proof of dysfunction than is the man's single, localized symptom of sexual weakness.

The onset of senescence is destructive to the ego not alone in its suggestion of sexual impotence, for the growing awareness of diminishing capacity in other areas of activity is often disastrous as well. We see frequently that the simple change represented by retirement from business is a shock which some men cannot take in stride and to which they sometimes seem to react by severe anxiety and even death. Recent study of aging (geriatrics) has revealed much valuable material regarding the conflicts and solutions developed in senility. Frequently complicated by illness of greater severity, at a point in life when physicial resiliency is at a minimum, the disintegrating process that culminates in death begins psychologically long before death actually takes place. It is during this process of gradual frustration that the total assets of the personality are fully tested.

Illness

The manner in which old age serves as a frustrating reminder of incapacity is, of course, entirely similar to the effect of any other experience of restriction of the ego; one such restriction is illness. The psychology of illness is a matter highly complex and one to which at least brief consideration must be given. At the outset we must regard illness primarily as a situation of frustration, a reduction of capacity that is variably tolerable or intolerable to the individual. Illness places the individual in a situation of restricted activity on the one hand and of dependence on the other. Neurotic solutions to this frustration are revealed in the degree to which some individuals acquire an exaggerated dependence on others for help—sometimes a severe or prolonged illness seems primarily responsible for overdependence in later life.

The fact that almost by definition physical illness is universally regarded as a situation requiring help and sympathy from others gives it a unique significance always in the life history. The indi-

vidual frequently ill from whatever cause or causes enjoys during his illness a degree of attention and ego reassurance that may be significant in the interpretation of later solutions to frustration. In the same way, recovery from physical illness, requiring as it does the gradual weaning from extra attention and increasing reliance on the self, often seems to serve as an added frustration that some individuals tolerate poorly.

An excellent description of the patient's restriction and of his changing needs and frustrations is provided in the following description by Philip Wylie (148) of his illness:

When we were children and the mysterious "infantile" epidemic was in the summer air, the dust, the water—somewhere—my brothers and sisters and I worried for ourselves, along with our parents. Our eyes and noses streamed daily argyrol in an attempt at prophylaxis, and even though that treatment was somewhat harsh, we did not mind it because it was overshadowed by our fear. Then I grew up. The incubus left me as it leaves most adults, since they are relatively immune to the disease. I made an occasional contribution to the campaigns for funds with which to fight the affliction. And whenever I saw the slow swing of a child on crutches, the small steel braces and the usually game grin, I felt the pity we, all of us, feel upon such occasions. It was an unknowing kind of pity—real, but generalized.

One summer, in a hotel in Warsaw, I collapsed with some undiagnosed illness. There was no doctor to tell me at the time. There followed a week of fearful sickness, weeks of convalescence, and transportation by stretcher and by train first to Paris and then home to New York. In the meantime, I gradually lost the use of one leg and one arm. My paralysis became absolute—muscles atrophied and became useless. When I was hospitalized in New York, I had lost the use of a foot and a hand and one arm. There was no certainty that their function would return to me and great doubt that it would ever be complete. That those doubts have since been removed is not part of this account.

The part I would like to write, and the part for which my talent or any other is insufficient, is a report on paralysis itself. For I know what it is. And the children who suffer from it need all the spokesmen they can find. To that cause, let me add a little bit.

It is not lost pleasures that hurt most of all, I think. Not the games played and the sports enjoyed—not hikes and picnics and riding bicycles and roller skating or driving cars, if you are adult. What hurts most is the frantic inability to do the small, essential, every-minute things. To reach the book across the room. Or the game. To get the pitcher on

the table if the glass runs dry at hand. To go to the bathroom. To close the window when it is raining in.

And it is not the frightful prospect of lifelong paralysis that is always the most alarming. Children—and grown people—are optimistic. They hope. But there are the deeply unconscious worries, the special fears, the often unspoken torments that can come especially to haunt the quiet, private thoughts of the paralyzed person. The stricken child will brightly insist that it is all right in the house alone for a while. It will let its mother and father go to the early movie for a rest and for a little change. But no such child can escape the "what ifs." "What if" something happens? I know; adults can get the "what ifs" too.

And the frustration of paralysis is not by any means just the tedious, endless frustration of immobilization. It is the frustration of mobilizing others to do the trifling things in your stead. To get a clean handkerchief. To write a letter. To empty the vase of dead flowers. To help you as small a distance as to the window to see a parade. Attendant angels would not reveal to the victim any irritation at this use of themselves as extra legs, although few human beings can fail sometimes to show their fatigue at the eternal necessity of it. But even a failure to reveal personal discomfiture would not settle the spirit of the sufferer, for the trouble lies not only in an awareness of the hardship worked upon others but also in the fierce frustration of being unable to do these things for yourself.

And yet, that is not a selfish frustration. What crippled bird fails to exhaust itself in an effort to fly? What wounded animal in an attempt to rise and to run? The urge to do things for yourself is biological and innate; an interference with it is a peculiar and terrible experience.

Then, there is recovery—the slow, inchmeal, effortful return of feeling, control and use in a paralyzed limb. Here may be a final trial of character, for there are obstacles to be overcome by the human will power alone. The will of children. Will power that has to be like a rod of steel to make the body bend, lift, turn, wiggle at all. And each new day is a new challenge to throw this keener determination against the unwillingness of the flesh.

This is known to me from experience—a shorter, less terrible experience than multitudes of children endure. But when I recommend their courage to you, it is to point out their need. For the difference between lifelong paralysis and complete health, in my own case, was money. A lot of it. And that, tragically, is the difference in theirs. Kids, little kids—and I would like to compress a world of pain and triumph in the phrase if I could—have all the rest of what it takes. (Page 104.)

The delirium that sometimes is seen to accompany fever is to be recognized as an elaboration essentially psychotic in nature; it may

be characterized by any of the elaborations verging toward the schizophrenic: epileptic, paranoid, depressive, manic, and autistic withdrawal. When these psychotic features are maintained for long and are a prominent feature of the illness, the diagnosis of psychosis is sometimes given in association with the type of infection (or drug or poison). These diagnostic possibilities are provided in the Appendix.

Brain Disease

With respect to psychopathology certain diseases—those that involve the tissue of the central nervous system and in particular the brain—require special consideration. The damage of brain tissue is a process largely irreversible. To the extent in such cases that psychological functions are thereby eliminated, recovery might be seriously curtailed or even rendered impossible.

Because of its special function as a coordinating center for all vital and behavorial activities, damage to the tissue of the brain more than to any other part of the body is likely to induce frustration. Following such illness or as its reflection we often observe severe neurotic and even psychotic solutions to the anxiety aroused. Almost any illness that affects the tissue of the central nervous system may have psychopathological sequelae; some of the most important diseases from this point of view are epidemic encephalitis, syphilis of the brain, and hardening of the (cerebral) arteries.[1] Even these diseases of the brain are not necessarily followed by psychopathology. We cannot assume, therefore, that brain disease alone is a frustration followed invariably by neurosis or psychosis.

Like his response to other frustration, the patient's solution to the anxiety attendant upon brain disease may assume the characteristics of a neurotic orientation or a psychotic elaboration again covering the increasingly schizophrenic possibilities of epileptic, paranoid, depressive, manic, or autistic elaborations.

In *encephalitis,* a disease that often attacks its victims early in childhood, the psychological sequelae often appear initially long after actual infection has subsided; sometimes they are the only symptoms of the neurological event. Since it may involve practically any area of the brain, the disease may be followed by severe incapacitation such as mental deficiency or mutism. In postencephalitis we frequently see behavior that is strikingly similar to

[1] An excellent description of the psychology of arteriosclerosis is provided in *Ultima Thule,* by Henry Handel Richardson (114).

that of the psychopathic personality. Such behavior in its milder forms may be revealed by impulsiveness, lack of judgment, and even antisocial aggression. Again, one often observes driving restlessness and activity quite incongruous in degree to the demands of reality, behavior that in its psychotic extremity is essentially manic.

When it is expressed in behavorial changes, syphilis of the brain is designated as *general paralysis* or *paresis*. Here also when pathological, the solutions may take any alternative in the continuum toward schizophrenia. One frequently finds anxiety, epileptic seizures, paranoid delusions, and depression. Frequently observed are manic characteristics such as grandiose delusions and hyperactivity. Since neurologically the disease is frequently one of progressive degeneration, in its extremity it may be represented behaviorally by the complete incapacity of idiocy.

The changes following *cerebral arteriosclerosis*, a disease that attacks the individual usually at the onset of or during senility, often appear to reflect involutional and senile frustrations as well as actual brain disease. Here again the whole range of solutions from the neurotic to the schizophrenic may eventuate.

Sudden Loss of Consciousness

Of particular significance as a frustration to the individual is the sudden loss of consciousness induced by injury. In illness that is gradually deteriorative such as senility the increasing sense of inadequacy seems to be focal to the individual's personality, as revealed in neurasthenic preoccupation, depression, and sometimes in agitation. Possibly because of its suddenness and completeness, loss of consciousness seems to act similarly but as a particularly conclusive reminder of incapacity in the face of environmental stress. Kardiner (74) considers the traumatic loss of consciousness to be a destruction of the effective ego, an event that to the personality may be catastrophic. Some individuals seem to be able to endure this frustration without serious disturbance to the personality, but for many others the anxiety aroused thereby is tremendous, to be reduced only by means of solutions that are of serious neurotic and psychotic proportion. To refer to these severe distortions considered to be induced by the shock, the terms "traumatic neurosis" and "traumatic psychosis" are frequently used. Kardiner describes at least seven varieties of stabilized (not immediate or acute, but chronic) solutions following the sudden loss of consciousness in battle;

sensory-motor disorders, autonomic disturbances, transference neurosis, hypochondriasis, defensive ceremonies and tics, an epileptic symptom complex, and schizophrenia. While this terminology differs slightly from that used throughout this book, examination of his case material reveals the progression here is over almost the whole range of solutions from hysteria to schizophrenia.

Complicating the picture clinically and theoretically are the facts that loss of consciousness occurs most frequently in connection with concussion of the head and that such concussion may involve damage to the brain. Not only may the individual demonstrate anxiety in his behavior (directly or indirectly as reflected in inadequate solution) but he may demonstrate also specific incapacities reflecting localized injury. Reductions of capacity associated with injury as well as disease to the brain may be revealed in disabilities such as amnesia, aphasia, paralysis, deafness, or blindness. Because these phenomena also are often hysterical, it is essential that the nature of the episode and the patient's reaction to it (and recall for it) be examined very closely. Such symptoms require careful neurological appraisal.

An aspect of the symptoms that appear following an admitted accident to the individual is that concerned with financial compensation. Naturally, motivational factors are important in all cases. To the extent, therefore, that the patient's gain is derived even unconsciously from the demonstration of incapacity, his choice of solution must be considered neurotic—a social justification of inadequacy.

Predisposition

We have considered some of the common sources of frustration and the variety of solutions to its attendant anxiety. The reader now may well ask any of the following questions:

What determines how the individual will react to frustration?

Why should he react so severely to one particular situation (rather than another)?

Is there for all persons a degree of frustration that is intolerable, a breaking point?

If people are predisposed to react inadequately under certain conditions, to what extent is this determined environmentally in early experiences and so possibly preventable?

The answers to these questions revolve about the general question

of the predictability of behavior, a question that has always represented a challenge to investigators and has received equivocal answers. In the brief discussion that follows we shall attempt merely to present a few aspects of the problem that seem to be of practical significance in clinical study.

At the outset it may be stated that on the basis of our knowledge today, it is impossible from clinical evidence to predict future psychopathology accurately. Predictions are most accurate in cases that reveal obvious pathological symptoms; even here the future course of maladjustment is predicted only as "prognosis hopeful" or "doubtful." Since methods of reeducation (or treatment or therapy) are steadily improving, the optimism of prognosis may to some extent be altered. For those mental diseases which approximate the psychotic and which involve physical pathology such as advanced syphilis, the over-all prognosis is generally poorer than it is for the forms of expression that are neurotic and, in particular, hysteric. Without pathognomic signs of psychosis or neurosis historically or clinically, the prediction that either will develop, based as it must be simply on an appraisal of the history and personality of the normal individual, is extremely tenuous. One of our greatest difficulties is that we know so little about the early signs of maladjustment. Until recent years, schizophrenia was considered present only with the appearance of irrational or hallucinatory or delusional behavior. Not until the psychogenesis of the schizophrenic personality was described by Bleuler, Freud, and particularly Jung was the disease considered in the light of a long period of germination dating back to conflicts in early childhood. Reviewing case histories of children who later developed inadequate solutions, Kasanin and Veo (77) reported that "especially in the schizophrenics, the beginning of a personality disorder was observed long before the objective criteria of mental disease became apparent." (Page 414.)

We have seen that in the progression from hysteria to schizophrenia, the solution developed seems to be related to conflicts in the more remote past, the heterosexual focus of which becomes of diminishing significance. From this we might infer that in the progression from hysteria to schizophrenia the period of pathogenesis tends to be longer; the prepsychotic personality of the schizophrenic is established more rigidly at a given point in adolescence, let us say, than is the preneurotic personality of the hysteric. This need not mean necessarily that in hysteria infantile conflicts are less signifi-

cant than they are in schizophrenia; it might mean that the schizophrenic solution to infantile conflict, whether or not earlier initiated, became earlier focal to and determinant of the developing personality.

A relationship such as that suggested above is supported particularly by consistent observations of the prepsychotic personality of patients who under various circumstances develop psychopathology. In a group of cases that as adults had demonstrated serious psychopathology Birren (18) was able to find record of psychological examination of the patients as children. The earlier examination was made because, for one reason or another, school adjustment was problematical. He reported that

> The children who later become schizophrenic tend to be apathetic in the childhood examining situation and are also more intelligent when compared to the constitutional mental disease group, who are excitable and of lower intelligence. . . . Apathy in the test situation precedes seclusiveness in the pre-psychotic period, a withdrawing type of adjustment to the hospital routine, and a very poor prognosis for recovery. (Page 95.)

In earlier discussion it was shown that Titley (139, 140) found a pattern of prepsychotic personality in patients who developed agitated depression identical with that of involutional melancholia, one characterized by rigidity, overconscientiousness, reserve, and narrowed range of interests. This is a finding that suggests that long before the onset of the psychotic symptoms the inadequate solution had been acquiring a fixed pattern.

Similarly, in an analysis of the history of patients who developed psychoses associated with arteriosclerosis, Rothschild (121) inferred that

> The observations suggest that individuals who are in any way handicapped psychologically are highly vulnerable to arteriosclerotic psychoses. A considerable number of patients displayed inadequate and unstable personalities; less frequently, situational stress was noted. Such patients break down mentally in the face of damage which persons of a stable makeup could easily withstand.
>
> Extensive central changes may produce a psychosis in anyone, but the anatomic factor can be regarded as all-important in only a minority of the group. In other cases, responsibility for the psychosis is shared by factors of personality. (Page 505.)

So much for the significance of the personality in the face of the frustrations of involution and old age. What of those solutions that

are considered to be precipitated by sudden trauma? In a recent study of the case histories of 41 patients who were considered to have developed traumatic psychoses, Moros (100) concludes

> In view of the poor background usually encountered, even if any one individual is not definitely prepsychotic at the time of the injury we still cannot exclude the rather likely possibility that he would have eventually fallen by the wayside, if not early in life, then in later years with the ripening of the crop of mental ailments associated with the process of ageing. (Page 54.)

It is interesting that the history of cases that here developed psychotic (rather than neurotic) solutions revealed so consistently a poor background.

Our position in regard to epileptic behavior is that the seizure is in itself a solution to anxiety in which the discharge of hostility has some utilitarian value. However, because the seizure, particularly when repeated, is presumed by many to be potentially damaging to the brain, psychotic phenomena that appear later are of post-traumatic interest. After intensive study of cases of epileptic psychoses Davidoff, Doolittle, and Bonafede (33) conclude that their development

> . . . particularly of the chronic type, is seen most often in individuals who possess poorly integrated personalities. The symptoms and prognosis in the chronic psychoses are dependent to a great extent upon the personality of the epileptic. Even in the group which shows mainly intellectual deterioration, a large percentage of schizoid or introverted individuals are found. Their reactions are not typically schizophrenic but resemble the schizophrenic-like pictures observed in organic psychoses. (Page 183.)

Epileptic phenomena, when they appear, are likely to occur in those individuals to whom the necessity to give vent to repressed hostility is of cardinal significance. Epileptic seizures appear often in association with neurotic and psychotic solutions and seem in some cases also to alternate with these as substitute outlets. An interesting case is described by Denny-Brown (34)—one of traumatic injury.

> The apathetic state of one patient six months after a severe head injury appeared to have no explanation in his current anxieties or in intellectual impairment. I found him one morning in the hospital ward in a severe major convulsion, the first he had had. Following this his apathy was gone. His electroencephalogram was slightly abnormal before and after

this incident, but not sufficiently so to identify it as an epileptic record by the electroencephalographer. The depressed irritable mood for some hours, often days, before an attack is often noticeable even in localized Jacksonian attacks from localized brain injury. (Page 588.)

Summary. These brief excerpts from only a portion of the literature dealing with the personality of the individual prior to the onset of severe symptomatology are sufficient to show that to a great extent prior to the frustrating event the pattern of response is cast. As the individual becomes older, his personality is less resilient; in the face of life's burdens he is under gradually increasing pressure to utilize all the forces of control at his disposal. To the extent that these are inadequately or unevenly or inappropriately developed, they serve as decreasingly reliable insurance of adjustment. We have seen that severe frustration at any stage in life may be followed by marked change in the mode of adjustment, the nature of which is considered to derive very largely from the dynamic properties of the personality prior to the frustration. This dynamic potentiality is structured largely by a process of conditioning, a phenomenon that, most effective early in life, becomes of diminishing significance as adulthood is approached and experienced. In referring all personality development to early conditioning, however, we limit our consideration alone to environmental influences: we must eventually consider also the stuff upon which these environmental influences act. Certain determinants of the personality are, indeed, impervious to change—aspects such as one's sex, one's skin color, one's bodily proportions. To what extent may these relatively inalterable characteristics predispose the individual to frustration and toward a particular pattern of reaction? In the sense of being determined by the chromosomes, there is little evidence that personality is hereditary. There is considerable evidence, however, that inherited factors may be strongly influential in casting the personality pattern, acting in this sense as conditioners. Among such are handedness and hereditary disease (such as hemophilia and color blindness). Depending on the environmental milieu in which the individual develops, no one of these characteristics need necessarily exert any importance in conditioning the personality. But in some situations, left-handedness may serve as a frustration, hemophilia may seriously limit one's spontaneity, and color blindness may disqualify for a particular job. In much the same way the inherited physical characteristics upon which social premium is placed may

contribute more or less to the individual's opportunity for adjustment, to the potentiality for success or frustration, and to the means for substitute satisfaction eventually developed.

Despite multiple studies of racial differences, there is no substantiation of the popular idea that the Negro inherits less capacity than other groups. Proof is not needed to recognize, however, that his inherited physiognomy forces him into a social minority faced with discrete frustrations and that these certainly condition developmentally the ultimate personality pattern. The Hollywood star, who owes at least a passing debt to heredity, may suffer grievously when the box office fails to sustain the integrity of her ego.

Not all interpretations of the relationship between physique and personality emphasize in this way the degree to which one's constitution engenders a unique conditioning. Most interpretations argue that since personality patterns and bodily types show a correlation, even though of negligible extent, both are constitutional (*i.e.*, inborn, hereditary). The most prolific student of these mind-body relationships in recent years is Sheldon, whose somatotypes are in general representative of the types described earlier by Kretschmer and others. Sheldon describes three components of the somatotype that he feels are, with relative purity or in admixture ("dysplastically"), represented in all individuals; these are the *endomorphic*, the *mesomorphic*, and the *ectomorphic*. These, he believes, are correlated with three distinct groups of personality traits: *viscerotonia*, *somatotonia*, and *cerebrotonia*. His descriptions (127)[1] of these are as shown on page 242.

The three components of the somatotype—the endo- meso- and ectomorphic—are similar in description to the types described by others as *pyknic*, *athletic*, and *asthenic*. In the light of our previous discussion it is interesting to consider the descriptions of personality that Sheldon provides. In a general way, the picture of cerebrotonia would seem to correspond to that which we have called the schizophrenic personality, while the picture of somatotonia suggests that which we have described as masculinity. When we consider the third component, viscerotonia, there appear to be factors that we have considered primarily both feminine and extratensive and therefore predisposing in extremity to hysterical solutions. Sheldon makes the interesting observation that the ectomorph, relative to his

[1] Reprinted by permission of The Ronald Press Company, from *Personality and the Behavior Disorders*, J. McV. Hunt (ed.).

Somatotype Component	*Personality Group*
When *endomorphy* predominates, the digestive viscera are massive and highly developed, while the somatic structures are relatively weak. . . . Nutrition may of course vary to some degree independently of the primary components. Endomorphs are usually fat but they are sometimes seen emaciated . . . (Page 540.)	*Viscerotonia* . . . in its extreme manifestation is characterized by general relaxation, love of comfort, sociability, conviviality, gluttony for food, for people, and for affection. The viscerotonic extremes are people who "suck hard at the breast of mother earth" and love physical proximity with others. The motivational organization is dominated by the gut and by the function of anabolism. The personality seems to center around the viscera. The digestive tract is king, and its welfare appears to define the primary purpose of life. (Pages 542–543.)
When *mesomorphy* predominates, the somatic structures (bone, muscle, and connective tissue) are in the ascendancy. The mesomorphic physique is . . . hard, firm, upright, and relatively strong and tough. Blood vessels are large, especially the arteries. The skin is relatively thick with large pores, and it is heavily reinforced with underlying connective tissue. The hallmark of mesomorphy is uprightness and sturdiness of structure, as the hallmark of endomorphy is softness and sphericity. (Page 540.)	*Somatotonia*, the second component, is roughly a predominance of muscular activity and of vigorous bodily assertiveness. The motivational organization seems dominated by the soma. These people have vigor and push. The executive department of their internal economy is strongly vested in their somatic muscular systems. Action and power define life's primary purpose. (Page 544.)
Ectomorphy means fragility, linearity, flatness of the chest, and delicacy throughout the body. There is relatively slight development of both the visceral and somatic structures. The ectomorph has long, slender, poorly muscled extremities, with delicate, pipestem bones. . . . The hallmark of ectomorphy is the stooped posture and hesitant restraint of movement. (Page 540.)	*Cerebrotonia* . . . is roughly a predominance of the element of restraint, inhibition, and of the desire for concealment. These people shrink away from sociality as from too strong a light. They "repress" somatic and visceral expression, are hyperattentional, and sedulously avoid attracting attention to themselves. Their behavior seems dominated by the inhibitory and attentional functions of the cerebrum, and their motivational hierarchy appears to define an antithesis to both the other extremes. (Page 544.)

mass, has the greatest sensory exposure to the environment. "He is thus in one sense overly exposed and naked to the world . . . , *i.e.*, biologically 'extraverted.'" Psychologically, however, he is introverted. While Sheldon does not suggest that this "exposure to the world" creates for the ectomorph a special situation that we might call "exposure frustration," from the dynamic point of view this psychological possibility cannot be ignored. Perhaps the mesomorph, endowed physically with the capacity for aggressive action, has also a higher frustration threshold, and so is less subject to shock. Less able to achieve satisfaction actively than the mesomorph, yet more adequately padded than the ectomorph, the passive and dependent endomorph is likely to be frustrated most when nurture is denied his basic needs: those typified by viscera that are large and massive. Thus as factors that later describe or prescribe or limit activity and so determine the nature of the conditioning process the physical characteristics of the individual are seen to be important. In the adult personality these naturally are sometimes reflected, but as wealth or poverty are reflected. Seeing a patient for the first time who is a poor physical specimen one is impressed immediately with the probability that the patient has developed internalized compensations for the frustration of ill health. Recognizing another patient as an athlete suggests the probability of certain social success in college.

The fact that psychopathology tends to run in families has long been recognized and interpreted as evidence that the child is endowed genetically with behavioral tendencies. Today we are inclined to feel that this endowment stems less from direct inheritance than from an environment in which instability (in parents, for example) operates as a social influence on the developing child. However, the older view that personality factors are directly inherited achieved wide acceptance and is maintained strongly even now by many of those associated professionally with psychopathology. That one may receive a hereditary taint toward insanity is a concept basic to legislation for the sterilization of the psychotic, which has been initiated in several states.

Of particular interest in the consideration of heredity and behavior is the evidence gathered by means of electroencephalography—the brain waves. Of the many components of the electroencephalogram, certain are found to be relatively impervious to change and are therefore considered constitutional. To the extent that these unchange-

able wave components can be considered as reflections of behavior, then such behavior might also be considered of permanent nature and essentially constitutional.

Members of the same family tend to have similar wave patterns. One pattern that is found to run in families and to remain relatively unchanged throughout life is that described as *cerebral dysrhythmia.* Revealed by about 15 per cent of the population, this pattern occurs in somewhat greater incidence in cases of various psychopathology and in greatest frequency in persons who experience epileptic convulsions. Because of the high degree of association between cerebral dysrhythmia and epileptic seizures, some clinicians feel that idiopathic epilepsy is a disease largely inherited, a viewpoint in some degree contradictory to that developed in the previous chapter—*viz.*, that epileptic seizures are essentially psychosomatic solutions to anxiety. The emphasis on cerebral dysrhythmia in association with epileptic phenomena serves to distract attention from the fact that the dysrhythmia, whatever its significance, also occurs in considerable frequency in other forms of psychopathology in which paroxysmal seizures are absent. Actually, the dysrhythmic pattern seems to reflect a constitutional tendency that, like left-handedness or color blindness, might serve as a frustration for which the solution might well be psychopathological. That there may be a greater frequency of epileptic solutions than others among dysrhythmic individuals might suggest that the epileptic's way out—the nature of his solution—is in some way more satisfying to the basic needs of such individuals than are other solutions. Possibly the dysrhythmic individual in particular requires the relaxation that Bartemeier suggests as the beneficial effect of the seizure. It should be emphasized that many dysrhythmic individuals never exhibit psychopathology (including epileptic behavior), a fact that indicates that in these individuals this constitutional frustration is apparently tolerable.

Of the factors that are inborn and constitutional, one of the most potent in determining personality development is the primary sex of the individual. The difference between maleness and femaleness depends on many factors—some subtle, such as interests, attitudes, and endocrine functions; some obvious, such as body contour. The most obvious characteristic at all ages is the presence of the typical sex organ, and it is in this strictly anatomical sense—the presence of the testis or the ovary—that we discuss the matter here.

In an excellent discussion of constitutional factors, under the

heading "The Mosaic of Androgyny," Draper, Dupertuis, and Caughey (36) present a detailed analysis of the sexual constitution. They show very clearly that certain physical diseases occur more frequently among men than among women, while others occur more frequently among the latter. Figure 4, taken from their book, shows, for example, that duodenal ulcer is a male disease, while hyperthyroidism is female. Both these diseases are considerably psychosomatic. While the metabolism of the male, according to the authors, is an expending, energetic, active metabolism (like Sheldon's mesomorphic somatotonia), that of the woman typically is conserving and passive (viscerotonic). Significantly, when female diseases occur in men, they occur in men of predominantly the "gynic" or female body type, while women who develop masculine diseases tend to be "andric." The authors suggest that alcoholic women are usually andric, that under the influence of alcohol feminine women become more masculine. The chart reveals that alcoholism is a typically masculine rather than a feminine affliction.

So much for the physical illnesses and their sex incidence. What of maladjustments that we consider primarily psychological? Are there sex differences that suggest that mental diseases and neuroses also are typically male or female? The answer to this question is not at all simple. Statistics suggest that among men psychosis is more frequent than it is among women. One reason may be that psychosis is often associated with alcohol and syphilis. Statistics suggest also that, whereas paranoid reactions, epilepsy, and to a slight extent schizophrenia (before thirty) tend to occur more frequently in males, women are more addicted to depression and the diseases of old age—senility and involutional melancholia. Psychopathological syndromes, unlike those in Fig. 4, have not been found closely correlated with the androgynic body type, so that the suggestion of hereditary relationship is considerably reduced.

When we consider the diverse tendencies implicit in the normal sexuality of male and female, the significance in psychopathology of the single constitutional fact of sex is made manifest. In the passive female, achievement of security depends to a greater extent on physical attractiveness than it does in the male; frustration is for her more often associated with physical limitation such as unattractiveness. Hence, a feminine quality is extratension itself. It is not surprising that in women hysteria and neurotic expressions—*i.e.*, solutions that are socially oriented—are achieved more frequently

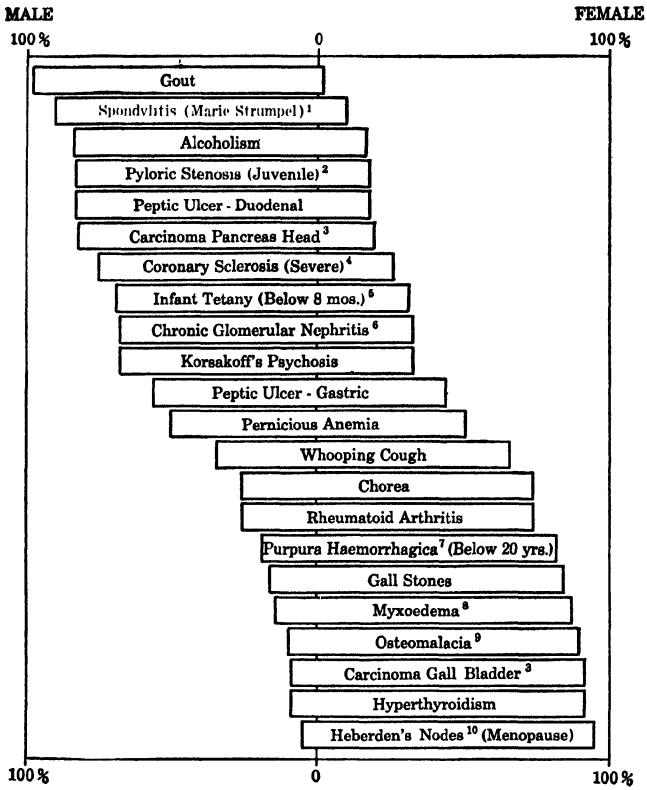

FIG. 4. "Differential Sex incidence in disease susceptibility." (*Adapted from Fig.* 18, *p.* 89, *of* Paul B. Hoeber, "*Human Constitution in Clinical Medicine*," *Harper & Brothers*, 1944, *by permission of authors and publisher.*)

than they are in men. Because in men, by contrast, greater premium is placed on aggressiveness and activity, it is understandable that the solutions that are personally elaborative are more representative.

[1] Spondylitis (Marie Strumpel): a progressive and disabling arthritis that usually appears in early maturity, in the sacroiliac vertebrae and is characterized by bone changes.

[2] Pyloric stenosis: obstruction of the pylorus of the stomach.

[3] Carcinoma: cancer.

[4] Coronary sclerosis: hardening of the coronary arteries, which supply the heart.

[5] Infant tetany: deficient calcium metabolism associated with parathyroid dysfunction.

[6] Chronic glomerular nephritis: Inflammation of the glomerules of the kidney.

[7] Purpura haemorrhagica: A disease characterized by formation of purple patches on the skin or mucous membrane.

[8] Myxoedema: Extreme hypofunction of the thyroid.

[9] Osteomalacia: Softening of bones associated with vitamin D deficiency.

[10] Heberden's nodes: Nodes which appear on the fingers in advanced life.

When we consider other aspects of sexuality it is further apparent that the belonging to one sex or the other predetermines to a great extent the direction of inadequate solution. Of conflicts that are focal to the various inadequate solutions, those found to eventuate in the hysteric, neurotic direction are usually associated with heterosexual adjustment, while those earlier developed conflicts found precursor to the psychotic solutions are more often associated with homosexuality and with masturbation. It has been emphasized that for several reasons homosexual and masturbatory conflicts are more frequent among males than females, and it is reasonable therefore to consider that (schizophrenic) solutions to which such conflicts are central are, therefore, more typically masculine than feminine. This applies also to conflicts involving hostility and aggression. To be sure, women develop psychotic solutions; when schizophrenia develops in women it tends to develop later in life (thirty-five and beyond) and is frequently found in women who, disturbed by masturbatory or homosexual conflicts, are psychologically masculine. The woman's psychotic solutions are more likely to be affective reactions than they are to be emotionally flat. Reporting that, though schizophrenia in women is less frequent than among men, its death rate is higher, Scheinfeld (125) infers that the disease is in women more serious. Certainly for the woman schizophrenic elaboration represents psychologically a more serious reversal of position than for the man and may therefore in greater degree approximate catastrophe. By comparison with men, women in their urge toward individuality of expression tend to seek outward expression, as, for example, in clothes that are different. Men dress pretty much alike; they strive more to be socially inconspicuous. The urge for individuality of expression in the man is more likely to be revealed in his job or professional activity and, under frustrating conditions, in inner elaborations that like ulcer or schizophrenia are not at all socially oriented.

The constitutional fact of sex is seen to be important in predetermining the nature of solution to frustration, not because hysteria or schizophrenia are a function of the gonads, but because the gonads in our society represent discrete problems of adjustment. In the same way other inborn qualities of the individual—skin color or race, excessive height or diminutiveness, good looks, physical strength—in rendering the individual less or more likely to achieve goals in life may be considered predisposing to maladjustment.

CHAPTER XIII

READJUSTMENT

In this book so far our discussion has been devoted to the matter of maladjustment in its various forms. Occasionally, and principally as a contrast in defining maladjustment, we have referred to the positive process of adjustment—*i.e.*, successful adaptation to the demands of society. In the remaining discussion, concerned as it is with the nature of readjustment and reorientation, it is of signal importance at the outset to concentrate our attention, at least briefly, on the consideration of adjustment; only by understanding this positive rather than negative process will we be enabled clinically to predict just how the maladjusted individual may achieve a solution more adequate than that which he has developed.

We have used terms such as "adequate" and "successful" and "satisfactory" somewhat indiscriminately as modifiers of the terms "adjustment" and "solution." Since they are used so extensively it may be well to examine these terms more precisely.

It should be clear that the term *solution* applies to any adjustment that alleviates anxiety. To be satisfactory to the individual the solution to anxiety must somehow grant satisfaction to basic impulses that would otherwise be frustrated. The solution satisfactory to the individual is not necessarily compatible with social adjustment. But if the solution is acceptable or at least tolerable socially we regard it as evidence of successful adjustment. However, a solution may be entirely satisfactory to the individual, (in that basic impulses are satisfied) but wholly unacceptable to society, as in neurosis or psychosis. These solutions are unsuccessful because they are incapacitations—they reduce the individual's efficiency.

Reexperiencing Anxiety

It is apparent that in considering not only maladjustment, but adjustment and readjustment as well, the crux of the matter is anxiety. As we have seen, anxiety is not necessarily central to,

nor, indeed, even involved in, many manifestations of maladjustment. Among those solutions in which anxiety features are often no longer apparent we might include long-standing psychotic elaborations and deficiencies in capacity or motivation such as feeblemindedness or the psychopathic personality. Anxiety is, however, precursor at some time or other to all the various solutions along the axis from hysteria to schizophrenia—to the neuroses recently and to psychotic solutions remotely.

In cases of acute anxiety state in which the individual suffers not because of inadequate solution but because he has achieved no solution at all, readjustment is quite simply the achievement of successful solution to the present problem of frustration. For example, the man who becomes highly anxious at the prospect of a new job achieves successful adjustment only when he becomes somehow reassured of his competence to meet the new situation. In those maladjustments characterized by inadequate solutions to anxiety it is only through the reexperiencing of anxiety that more adequate solution can be achieved. It is for this reason that readjustment, at least during certain stages, is often a painful process. The patient who has developed neurotic or psychotic solution must reexperience the anxiety attendant upon the original frustration of basic impulses in order to achieve, as does the adjusted person, some solution that is both satisfactory and adequate.

We have seen that anxiety is a state of unpleasant tension—a condition that demands resolution. The question immediately comes to mind, "Is it not paradoxical to expect the individual who has achieved an inadequate but 'satisfactory' solution (as represented by neurosis or psychosis) to seek an alternative that, in rearousing anxiety, is essentially an unpleasant possibility, and, indeed, an experience from which the very development of psychopathology was an avoidance?" Why should one expect the patient to desire change since, even at sacrifice to himself, he has achieved a solution? The very definition of neurosis and psychosis is that these are satisfactions of basic impulses that, to the individual at least, suffice to reduce anxiety and so make life tolerable. Obviously, the patient must become dissatisfied with the solution he has achieved—*i.e.*, recognize at least in some degree that his solution is inadequate.

The degree to which the maladjusted person realizes that he is making a poor or inadequate adjustment is highly variable. He who

comes voluntarily to the clinician seeking help is, of course, at one extreme in terms of this motivational factor. At the other extreme is the individual—probably the criminal is the best example—who is forced against his will to submit to clinical appraisal. Between these two extremes lie the cases that form the vast majority of clinical studies—individuals who vary in intelligence, in the desire for help, and, above all, in self-understanding, or insight. We shall discuss shortly the particular significance of insight in the process of readjustment. It is important here to see that, no matter how keen his self-understanding, without motivation toward readjustment the individual is likely to achieve little success. The author recalls hearing of the case of an intelligent, neurotic young married man who had undergone the experience of psychoanalysis with three different clinicians. A fourth analyst refused to accept the case; as it appeared to him, the patient, married to an aggressive business woman who supported him financially, had more to gain by retaining or clinging to or falling back on his incapacity than by attempting to support himself. Since this was acceptable to the wife, who would pay for the psychoanalysis, very little hope for successful, constructive adjustment could be visualized.

All other things being equal, the maladjusted patient who, dissatisfied with his solution, comes willingly for help stands the best chance of achieving more successful adjustment. In itself the desire for help should not be interpreted superficially as evidence of strong motivation toward readjustment. Obviously, the patient just mentioned who sought a fourth psychoanalysis seemed to want help. But in his life situation, desire was for something other than to adjust to life more successfully, no matter whether what he really wanted was the security of an intimate relationship with another, the social prestige of psychoanalysis, or—in a situation that permitted such idle activity—the opportunity simply to indulge in fantasy. Many are the patients who come to the clinician seeking medicine or advice or rules to follow that might reduce tension, insure sleep, restore energy, and relieve minor aches and pains. In all such cases the need for physical treatment is, of course, a primary consideration. But, as we have seen, many such complaints of physical illness are only means of avoiding successful adjustment. Moreover, this very utilization of physical complaints reveals the patient's conviction that his illness, being physical, can be cured only by means of physical treatment—pills, massage, X ray, and

so forth. Seeking advice and treatment, such cases in particular are initially resistant to the idea that illness is in the mind, not in the body. Finding no organic basis for the patient's illness, the clinician may suggest to the patient that his headaches are a sign of nervousness. In many cases such a suggestion does great harm, for it either falls flat as an explanation of anything, or it stirs up immediately an antagonistic attitude—the clinician either doesn't know his job or he doesn't care. To the patient his own complaints are obviously important, or he would not seek relief. To the clinician the complaints, though there be no organic basis for them, are of critical significance, because they suggest the dynamics of neurotic solution to anxiety. They should be considered seriously, in agreement with the patient, not as handicaps to be thus recognized but as signs, acceptable to both patient and clinician, that the life situation of which the complaints apparently are a part is not as congenial or successful as it might be. In many such cases, the very emphasis that the patient gives initially to physical complaints can, by its integration into the life situation as a whole, serve to initiate effective motivation toward more adequate adjustment. It is indeed surprising to observe the ease with which the patient who is entirely absorbed in his pains and discomfort seems often to drop his complaints entirely when he feels free to consider larger aspects of his life quite without censure.

From earlier discussion of the various forms of maladjustment it should be clear that it is in their very nature that motivation toward successful adjustment is deficient or absent. The psychopathic personality lacks almost completely any motivation toward civilized adjustment. The psychotic individual is singular in the satisfaction he finds in his own world; he would not be expected easily to become discontent with it. Motivation toward readjustment is greatest, as we have suggested above, where tension and the discomfort of anxiety most typify the patient's present adjustment, *i.e.*, in the neurotic maladjustment in which anxiety is most pervasive.

INSIGHT

For the maladjusted individual to be motivated toward the achievement of successful solution to anxiety it is necessary first of all that he sense to some extent the inadequacy of his present adjustment. Often this comes about naturally, in the course of

time alone. The individual unable to work is likely eventually to suffer from the reduction of income more than he gains from illness and to realize gradually that some readjustment is necessary. Such natural readjustment undoubtedly characterizes the life pattern of many normal individuals, persons whose temporary maladjustments are not sufficiently incapacitating or intolerable to warrant clinical attention. Our clinical interest is, of course, centered on those cases in which the process of readjustment is slowed or arrested, for in such cases factors of minor significance in the natural process seem here to be acting as obstructing influences. One such obstruction, as we have seen, is the lack of motivation toward more successful adjustment. Focal to this motivational problem is insight—the degree to which the individual understands himself and his present situation.

The very nature of psychopathology is that it is characterized by lack of insight—maladjustment and insight are at variance. Persons on the surface well motivated toward achieving successful adjustment characteristically fail to see their complaints and incapacities essential as reactions to life's problems. The very nature of an inadequate solution such as neurasthenia, for example, is that quite unrecognized by the individual the natural expression of basic impulses is repressed and replaced by the symptoms themselves. Because of this repression, the patient not only fails to see his illness as a solution to frustration, but he resists the idea that such may be the case. He is resistant to the very development of insight. Hence it is that for the clinician simply to inform the patient that there is nothing wrong with him physically—that it is "all in your head"—is not only idle but usually harmful, for it serves only to antagonize the patient.

Insight is an achievement of the patient. It is quite unrelated to intellectual comprehension of one's psychopathology. Essentially, insight is an awareness of self in the dynamics of the present adjustment situation, an awareness of needs within and the possibilities for satisfying these needs in everyday living. Insight in the well-adjusted individual is revealed not in his intellectual understanding of personal assets and liabilities but rather in the awareness of emotional needs and of the means whereby these needs for expression may be met naturally and without conflict and satisfied in ways acceptable to others. Impulsive, the well-adjusted person may regret his indiscretion; aggressive, he may feel guilty for his hostility;

sexually aroused, he may restrain his impulse toward satisfaction. But neither these impulses nor their consequent anxiety are so dominant that they reduce in any great measure the individual's capacity. By means of checks and balances they are integrated into a successful pattern of adjustment and so accepted as realities.

We see then that in the readjustment process motivation toward more adequate solution is essential and that this motivation, in turn, is to a great extent determined by the degree of insight of which the individual is capable. But the development of this necessary insight itself requires certain capacity, which many individuals possess in limited degree. While insight, as we have seen, is something quite apart from the intellectual comprehension of personality organization, in that it implies a functional, useful awareness and acceptance of the self, it is nevertheless true that a relatively high degree of mental capacity is required for its development. In cases of mental retardation and in instances of the reduction of capacity the individual may be incapable intellectually of forming any concept of his situation, just as the child may be incapable because of intellectual immaturity.

In psychotic forms of adjustment the achievement of insight is particularly problematical, for here the very nature of the individual's orientation is an expression of autistic self-interpretation. In contrast to the neurotic, the psychotic individual is least likely to consider himself ill. For him, adjustment socially and otherwise may seem entirely satisfactory; he has, indeed, elaborated a social environment for himself, a pattern into which he fits ideally.

The process of readjustment, so greatly facilitated by the development of insight, becomes a less likely prospect in cases characterized by intellectual limitation or autistic elaboration. Thus, granting at least low average mental capacity, it is in the cases at the neurotic pole of the continuum from hysteria to schizophrenia that insight is most likely to develop. The psychopathic personalities of whatever capacity, since they are poorly motivated, are relatively poor prospects for readjustment. In this respect they are like children. The mentally deficient also are poor prospects, for, though they may be well motivated, they lack the capacity for insight. In the range of solutions from hysteria and verging toward the psychotic pole, then, lie those inadequate solutions that are most likely to reorient toward adjustment rather than maladjustment. This may be another way of saying that maladjustments of the relatively bright

neurotic, because they right themselves most easily, are handicaps less serious than those associated with mental retardation or with psychosis. Certainly it implies that cases of intellectual handicap and of psychosis, lacking the wherewithal for righting themselves, will require the most help from the outside. It is in such cases that anxiety in the present personality structure is most peripheral and remote and in which the reexperience of anxiety demands the greater jolt. As we shall see, it is in cases of psychosis that convulsive shock is most appropriate. This is not because the convulsion has no effect on the nonpsychotic. It is rather that the psychotic individual requires the more severe experience for the reawakening of anxiety than does the nonpsychotic.

One may now ask the manner by which anxiety is to be reexperienced by the patient, in order that he may initiate this process of achieving adequate rather than inadequate solution. To answer this question it is necessary for us to recall certain earlier discussion, particularly regarding the dynamics of neurosis and psychosis. We saw that, in normal childhood, fantasy in thinking and in action serves the purpose of satisfying basic impulses that are denied expression in everyday living. We saw also that dreams serve this purpose, even in adult life, though their content is sometimes so distorted that they represent satisfactions only symbolically. The whole dynamics of constructive and creative achievement as found in great art and science could also be related to this urge toward satisfaction of basic impulses, for these elaborations may be understood as sublimations.

Just as the individual may in substitute satisfactions constructively or destructively relieve anxiety, so in dreams does the anxious individual attempt to act out, as it were, a complete sequence of activity that might remove him from frustration. Nowhere is this better illustrated than in cases of the traumatic neuroses of war. Here the patient's intense and horrifying battle dreams are involuntary relivings of the scene of frustration, in an effort to achieve some successful solution rather than catastrophic ego deflation. In these cases of traumatic neuroses anxiety is highly prominent, at least during the stages in which the patient involuntarily experiences the nightmares of catastrophe. But in cases in which this anxiety is more remote—converted into physical symptoms or systematized ideationally—the process of reliving is not easily or naturally accomplished by the patient, and it is only through his dissatisfaction with

his present adjustment that he is likely to be thus successful. Conflicts that are the very core of the maladjustment-producing anxiety—be they feelings of frustration or feelings of guilt for aggressive impulses—these conflicts have been satisfactorily liquidated by means of the maladjustment itself; there is little motivation to reawaken these unpleasant feelings and deal with them directly. The patient who seeks help may want to find an alternative solution that he hopes will be successful rather than unsuccessful, but he is not readily willing in the process to pay the price of recognizing his own fears and limitations—his failure. Yet, unless he does achieve this self-understanding, this insight, his quest for adequate solution will be hopeless. Hence it is that many maladjusted individuals never achieve more adequate solution. The discomfort associated with understanding themselves is too great. Some others, finding maladjustment gradually unsatisfactory, through a process of self-evaluation and experimentation suddenly are faced with the unpleasant fact of their frustration and inadequacy, and hence with anxiety. But the great majority of maladjusted individuals for one reason or another needs outside help.

If this help toward self-understanding and acceptance were easily provided in the individual's environment, he would not require special consideration. Almost always in cases of maladjustment, however, the environment is such that the individual faces a barrier. Our society, with its ethical codes, its religious doctrines, its prejudices and taboos, rather fosters than discourages the repression of basic impulses. Certainly society does not relish illness and insanity, but it is even less willing to prevent or palliate or eliminate these by countenancing the recognition and acceptance of impulses such as aggression and sexuality. It is, indeed, precisely because of these repressive social forces that impulsive expression becomes distorted and inadequate.

For this reason, it is necessary in many instances of maladjustment that the patient simply be given opportunity to accept himself emotionally. The opportunity needs to be provided for the patient to understand and accept himself, his basic needs and impulses and their expression. Unacceptable impulses previously expressed in illness or directed toward the self in autistic elaboration require for their emotional expression an atmosphere in which they will not be rejected socially. Unless the patient can feel himself in a social atmosphere in which the primitive personality behind the barrier

will be accepted, the elaborate superstructure of repression will remain as rigid as ever.

Emotional Release

This process of reliving the conflict situation and so reexperiencing anxiety is a part of what psychoanalysts have called "abreaction." The total abreaction includes, not only the reexperience of anxiety, but the process also of experiencing in behavior or in speech or otherwise the release of emotional tension that characterizes anxiety and that facilitates successful adjustment. In achieving successful solution through the experience of abreaction the individual therefore not only reexperiences the anxiety and frustration focal to maladjustment, but in some way compatible with reality he also releases the pent-up emotional tension that characterizes his anxiety. Some are able to find this emotional release quite without help. How often do we observe perfectly normal individuals about us, frustrated by minor accidents—the door handle that falls off, the pen that will not write—give vent to anger in a curse or by throwing the damn thing across the room? The person who, when frustrated, finds emotional outlet in musical expression is in essence discharging emotional tension in a manner congenial to others. Indeed, the process of sublimation itself represents such an outlet, possibly more fixed and organized into the personality than the episodic outburst, but serving the same cathartic purpose.

While it is characteristic of the well-adjusted person that he finds outlets for minor frustrations without doing any great harm to others and without developing any real sense of guilt for his action, this is not true of the maladjusted. The neurotic or psychotic individual has for some reason been unable to give vent to his frustration; his inadequate solution developed as a consequence of the repression of this emotional expression and the substitution of the pathological symptoms themselves. That which distinguishes the neurotic or psychotic individual from others is his difficulty in finding outlets of emotional expression acceptable to himself and particularly to others. Even when anxiety is in some measure reexperienced, the maladjusted individual is usually faced with the same lack of opportunity for desirable expression—the social forces that acted so strongly to thwart him in his original frustration seem still as foreboding. Let us take as an example the child, raised by strict and domineering parents, who feels great hostility on many

occasions for the restrictions imposed. Under the code "Honor thy parents," direct expression of this hostility, and even the thought of it, is sinful, so that emotional reaction to frustration is repressed. Years later this pent-up hostility, still sinful and therefore unacceptable, is reawakened in part by the death of the parent. The child, now an adult, feels intense guilt, amounting to a feeling of personal blame for the death of the parent. This dynamic pattern often appears in cases of depression, which may be even suicidal in degree. Reminded during his childhood and youth that his waywardness "will be the death of your mother," the son, hearing news of her death, reexperiences intense anxiety and guilt and feels that his own life should somehow be sacrificed in atonement. While the patient in this way reexperiences intensely the anxiety of childhood frustration, he is aware not of filial aggression but only of the error of his ways; hostility is replaced by guilt. Such a patient does not readily find outlet for this pent-up emotion, so that only in suicide does he find expiation commensurate with his guilt. While such a case is extreme, it illustrates the fact that those patterns of social restriction that serve early to frustrate the individual and so eventuate in psychopathology tend also to retain their frustrative quality.

Fundamental to conflict in most instances of neurosis or psychosis is frustration in the search for love and recognition, aggression because of frustration, and the need for expression of this consequent hostility. In the cathartic process of readjustment the patient, reexperiencing anxiety, must find frequent outlet for the expression of hostility.

Release Outlets

Play. When we consider the means by which the individual may express basic impulses and so relieve the tension of anxiety, it is clear that a substitute must be found for open and primitive release. Obviously open aggression toward others would be in most instances catastrophic. The patient needs aggressive expression through some outlet that will provide release and yet will not be disastrous to others and so increase his frustration. Naturally hostility toward other individuals can be transferred to objects; the child, angry at frustration by his parents, takes it out on the cat. In the child's play we can observe the high degree with which he identifies himself with relation to his toys; this is particularly well shown in play with dolls. The child acts the parent role, now affectionate, now strict

and punishing. The doll is scolded and put to bed, left in isolation, sometimes spanked severely, or even destroyed savagely. In such ways the child is able to work off hostility that otherwise would go unexpressed. Levy (90), one of the first clinicians to study carefully this form of release in children, found very convincingly that the hostility of the older brother or sister toward the younger child was markedly reduced when he was permitted to work out his aggression on dolls. An illustration[1] of this is provided by the following report of one of his cases:

Case 4

Date 1st experiment: 3-8-34

Age:	3 years, 8 months
Sex:	Male
No. of siblings:	Two
Age of rival:	20 months
Sex of rival:	Female

Problems for which patient referred: Speech difficulty—retains "baby" speech.

Present status of sibling rivalry: No overt hostility with baby. No "bad reaction" at first meeting. (Problem considered a regressive response to sibling rivalry).

Interview in which experiment made: First. (Page 79.)

The situation provided for the child is described as follows:

The patient is told that we are to play a game. For the game we need a mother, a baby and an older sister (or brother). We use the amputation doll to represent the mother, a celluloid baby doll, and a larger doll for the older sister (or brother). The examiner says, "The mother must feed the baby." He then points to the chest of the amputation doll and says, "But she has no breasts. Let's make some." The examiner makes one breast, the child makes the other. This procedure is employed to facilitate the experiment since some children are hesitant about making breasts yet are free to do so if the examiner makes one first. After the breasts are placed in position on the mother doll, the baby doll is put in the nursing position, the mother's arms encircling it. The child is asked to name the baby and the sister (or brother).

The examiner then says, "Now this is the game. The sister comes and sees a new baby at the mother's breast. She (or he) sees it for the first

[1] Reproduced by permission of the author and of the American Orthopsychiatric Association(90).

time. Now what does she (or he) do? Do whatever you think." The child is encouraged with such phrases as "Go ahead," "Don't be afraid." The experiment may be repeated several times.

After the "controlled" situation has been utilized in this way, the examiner may then stimulate activity in various ways. These methods of releasing the rivalry are described in the individual cases. They consist largely in using such phrases as, "When the sister (or brother) saw the baby she thought, 'The nerve, at my mother's breast!'" Or the child is told, "That's really your baby brother and this doll here is you." (Page 9.)

Here are notes regarding the child's behavior:

Experiment: Trial I: Appeared very interested, then took brother doll and made him walk to mother. He then said, "I don't want to," cried a bit, said, "I don't want to," several times, . . . then, using the brother doll as a weapon, smashed the mother doll . . . , threw the baby down . . . , and looked at me anxiously. (I said, "That's good. Go ahead.") He then took the baby doll (a china doll) smashed it to bits . . . , and said, "Why did you tell me to smash it?" (I said, "Because you wanted to.") He took every large bit of the doll and smashed it with a stick . . . , then a hammer . . . into still smaller bits. Then he took the mother apart . . . and struck her with a hammer. He removed the breasts . . . , squashed them . . . , then put them on brother doll (a rubber doll), and then hit the rubber doll . . . , saying, "I can't break it, it's rubber." (I asked, "Why are you hitting the brother?") He didn't answer. Then insisted on more baby dolls. He smashed another . . . and after getting a third said, "No, that's a pretty one." Then got distracted and played with animal toys.

Trial II: Says, "I don't know." Then takes an automobile and says, "It's the mommy's automobile." Picks out another doll and says, "Where did you find it?" Asks for the hammer. Then picks out a china doll (in Trial II a celluloid doll was used as the baby) and smashes it to bits . . . Says, "I broke that baby up," and sings, "I broke that baby up." Finds another doll and asks, "Can I break this one"? (I say yes.) He smashes it again with a hammer and says, "That's very hard," then, "Now I break the head, and now I broke that up." Distracted and can't be led to the sibling rivalry play.

Trial III: Refusal to play with material.

Trial IV: (6th interview): (He kept away from sibling rivalry material for three interviews, meanwhile playing chiefly with water and baby dolls, wetting their "diapers," washing them, etc.)

When shown the sibling rivalry set-up, I gave the phrase, "The brother (using patient's name) says it's a naughty baby." He jumped on mother

and baby, squashing baby and mother. Then removed her breasts . . . Then carefully put her together again, got another baby and tried putting mother with arms around baby exactly as placed originally. Then went on to other play.

Trial V: (7th interview): Plays chiefly at diapering babies and wetting the diaper. He won't come near the sibling rivalry set-up. Takes as many things as he can get, every truck and every little animal figure. Dumps them all in wagon. Sticks lumps of clay in water, takes them out and puts them on trucks. Then runs the trucks, takes out the clay. Makes one truck bump another. Then runs them to the sibling rivalry set-up, which was placed on the floor, runs over mother and baby. Lifts trucks to hammer them down, then crushes brother doll, and then rolls trucks along and crushes down clay.

Trial VI: (8th interview): During patient's play, consisting mostly of putting marbles in a glass of water, then pouring the water from one glass to another, getting as many trucks as he could into the playroom, I added three baby dolls to his material. In pouring the water he got a lot of it on the table and on the floor. Then suddenly he pulled the legs and arms off the dolls, looked flushed, and threw them at me. He laughed and said, "What is that for?" pointing to some books. (I said, "Why did you throw the babies at me?") He said, "Because you wanted to eat me up." He then took the torsos of the dolls, broke them up with his fingers, and put all the parts together in a glass of water, then said, after a few minutes play in silence, "Now we must have a dinner," and enumerated the parts of the meal. "You must have some." He gave me the parts of the doll in a glass. I took some and we both put them in our mouths. Then suddenly said he wanted to do "wee-wee" in the glass that contained the parts of the doll, and quickly prepared to do it, though I didn't let him. He struggled but I finally got him to the toilet. (Pages 79–80.)

The experimenter, using a method of graphic as well as verbal analysis of the behavior demonstrated in this case felt that there was represented:

. . . an initial and copious release of hostility, after a rather strong blocking through passivity (saying "I don't want to" several times and crying). It is only after squashing the breast that a self-punishing act occurs, to be followed by primitive hostility to the baby with *spread* of hostility; *i.e.*, destroying more than the one baby doll.

This is followed by increasing restriction of movement and preventive measures. In Trial II, passivity, primitive attack on baby and spread, then escape into distraction. In Trial III, he refuses to have anything to do with the material, and keeps away from it for three interviews. In Trial IV, there is quick destructive attack on all the objects, followed this

time, however, by attempts at complete restitution. Because of the impulsive nature of the attack and strong restoring efforts, the experiment continued until activity with the material became freer yet "easier." (Page 53.)

Regarding readjustment, the following notes are of interest:

The speech difficulty was no longer a problem by the sixth interview, at which time overt hostility to the baby was manifest. It took the form of hitting and pushing when in the presence of adults, who usually made much of the younger child, to the neglect of the patient. The hostility rose to its high point a month after onset, and receded to its present status after a period of about four weeks. At present (two years after the first trial), the manifestation of sibling rivalry occurs only when strange grown-ups make a fuss over the child in the patient's presence, whereupon he makes bid for their attention; an interesting change from a regressive response to an overtly hostile one. (Page 81.)

This brief report of Levy illustrates very beautifully the manner by which the child releases emotional expression in hostile behavior toward the dolls as symbols and so is able to achieve a healthier relationship with those in his real social environment.

Art. Projection of the personality in fantasy is achieved as effectively, though somewhat more symbolically perhaps, through graphic portrayal, as in drawings, painting, clay modeling, and finger painting. An excellent reference in this connection is the study of Guttman and Maclay (54). A patient's use of drawing as a means of achieving emotional release is provided in the following report by Naumburg (103).[1] He was a nine-year-old boy.

The information for this clinical summary was obtained from the patient's father who had not been in direct contact with the child, while away for six months on convoy duty. The mother had deserted her husband and child to go away with another man, a month before the patient was brought to the hospital by the father.

There is no history of mental illness in the patient's background but indication of neurotic trends on both sides of the family. The patient's father is of Italian and his mother of German parentage. The father is unstable, idealistic, completely dominated by his wife who is also highly neurotic, erratic and unpredictable in her behavior, which includes sexual promiscuity. Six years ago she fell in love with another man with whom she left her home. Since then she has gone out with many men, has taken alcohol excessively and has been sexually promiscuous. In October 1942

[1] Also reproduced in, "Study of the art expression of behavior problem children and adolescents, as an aid in diagnosis and therapy," *Nerv. Ment. Dis. Monogr.*, to be published, fall, 1946.

she deserted her husband and her only child to live with a married man who has 3 children and does not propose a divorce. She is said to have returned to her husband's home, but not to the marital relationship, a month after the patient had been hospitalized.

The patient has been exposed to the constant severe quarreling in the home since, at least, his fourth year.

An only child, the patient was said to have had devoted care from his mother during the first four years of his life. He was active, domineering and destructive with his toys, always preferring to play with younger boys, and was unafraid. After the onset of his difficulties, his symptoms included overactivity, marked sensitiveness, distractibility, tenseness, great need for attention and many fears, particularly in relation to physical injury. He began, at about four years of age, to tell fantastic tales and run away from home. These episodes increased in frequency and length as he grew older and truancy began to develop also. This behavior, it would appear, was a direct reaction to the catastrophic situation at home at the time when his mother had her first affair with another man. The parents were than on the verge of separation, but the mother refused to leave without her child and the father refused to give him up. From this time on the mother became progressively neglectful of the patient, often leaving him alone all night or keeping late hours to entertain many men friends.

The patient started kindergarten at the age of six and seemed to make a good adjustment, showing fondness for his teacher. During this year he was not afraid to fight with boys his own age, even taking on several at a time. When the patient was promoted to 1A, he refused to go to the new teacher and when taken to her he would cry, beg to be excused and not return to school. He would go for a walk and return home when school was dismissed. The father, coming home from a traveling job at eight o'clock one morning, found his wife asleep after a gay party and the patient greatly upset. The patient told his father that he had been unable to sleep, because there were people all over his bed and because his mother had been in bed with some other man.

The patient was studied at the Bureau of Child Guidance when he was six years old and was described as consistently negativistic, sensitive and hyperactive, showing great curiosity and destructiveness and resisting most attempts to work with him in play therapy. He gave the impression at that time of high average or slightly superior intelligence and showed unusual ability with manipulative materials, had a good grasp of the number concept, but had not yet learned to read or spell. He was defensive about talking about any of his inner feelings, would not discuss school and said he did not know why he ran away. He showed unusual tenseness and presented a more severe picture than the parents' story had indicated.

From the age of seven until the date of admission, the patient's behavior became progressively worse. His school attendance became more irregular and his absences from home grew longer. He had twice to repeat school grades so that he is now only in 3A.

The patient's father, when he returned home unexpectedly after a six months' absence on convoy duty, found his wife with another man and the patient locked in an upstairs room, screaming. On the following day the patient ran away from home. He returned at three in the morning just as his mother was leaving home with her lover. His father told him the circumstances; the patient showed great distress but was indifferently treated by his mother.

During the father's absence, he understands that the patient has been away from home for as long as 48 hours at a time on several occasions and with progressive frequency. Since the beginning of the school term he has attended school for not more than two weeks in all. During the month before admission, after the mother's desertion and while the patient was staying with his father, he ran away from home four times. When the patient was found he was always exhausted, having been long without sleep and without food, torn and dirty as though he had not washed at all. He greeted his father with indifference and communicated very little of his adventures. When the parents visited the hospital together, the child made a great fuss over the mother to the exclusion of the father whom he appeared to resent deeply.

On admission, the patient was a well-developed, well nourished 9½-year-old child with no remarkable physical or neurological findings. Laboratory tests were negative. Electroencephalogram showed no abnormal electrocortical activity.

The psychometric test resulted in an IQ of 96 on the Revised Stanford Binet. His performance test scores were very superior, suggesting special aptitude for an interest in working with manual materials. Attentional difficulties were marked, as was emotional reaction to the possibility of failure. Therefore his mental level was thought to be considerably higher than was evident on this test.

On the ward the patient appears unhappy, often preoccupied, seclusive, afraid of the older boys, unable to defend himself, constantly seeking the company of the younger children, unable to join in group activity, wandering restlessly around the ward. He is heedless and forgetful, often disobedient, unreliable, telling many fantastic stories to the other children and making efforts to get attention from both patients and nurses. He requires constant supervision, races about at times when the other children are performing their chores, hiding and refusing to do the smallest tasks. He cries easily and is a poor loser at games. He always remained a difficult supervisory problem but later showed a somewhat better adjust-

ment and told fewer fantastic tales. In the playroom he is superficially friendly with the examiner, is curious about the contents of the playroom drawers, restless and distractible, uncommunicative both about his feelings and his play efforts. He excluded the examiner from play, gravitated most often to soldiers and airplanes, and is destructive in his treatment of toys. At one time he said he would stay in the hospital until he was 14, when he would join the Marines and go and be killed by having his head shot off in the war. At the mention of either his father or mother, he became silent or evasive, and was totally inattentive whenever an effort was made to talk with him about his problems.

During his Christmas holidays with his parents, the patient ran away twice from an intolerable home situation; his acceptance of the hospital and his somewhat better adjustment here seems to date from that time. (Pages 32–34.)

. . . . .

The art periods with this patient began two months after hospitalization; they continued once a week, during five and a half months. Hour sessions did not seem too long, as is the case with many behavior problem children. Nick was encouraged to create spontaneously with any of the available art materials. These included crayons, paints and plasticine. While he remained tense and hyperkinetic, he was always eager and interested in the art work. He would usually open a session by announcing what he would make that day. Subjects in the ascendant, during the first few weeks, were jungle wars, sea fights and air-battles. His ceaseless commentary was filled with garbled versions of movies and comics adapted to his own phantasy life. While making these early war scenes, his speech was as explosive and fragmentary as the bombs and flames that filled them.

War games on similar themes, with equally vivid and episodic speech, were reported by the psychiatrist in her progress notes of the play sessions.

As Nick's confidence in his own powers to create on paper what was still buried within him grew, his preference for war scenes diminished. This symbolic release in art form of long repressed conflicts brought a degree of relief from the pressure of his anxiety and also led, with the help of accompanying conversations, to a growth of insight concerning his own problems. No interpretation was given to the patient at any time about the meaning of his symbolic drawings. For, to the writer, the therapeutic value of such art expression does not depend on interpretation but rather on its value as an image language of the unconscious.

Nick became increasingly interested in the growth of his ability to use crayons and paints so as to express his own inner feelings and ideas. When this improvement in his work was noted and praised he was much pleased and responded with the ambitious announcement, "I'm going to be the best artist in the hospital."

What Nick is not yet able to state in words, he now projects in the unconscious symbolism of his art. Here in battle scenes, the pressure of his anxiety first forces the expression of his hostility and insecurity into pictures of war. Gradually the deeper aspects of this boy's traumatic experience, which had long been inaccessible to verbalization, begins to be released in the unconscious imagery of his designs. As Nick gains confidence in his ability to express his buried thoughts and feelings in the safe disguise of pictures, he grows gradually more able, through accompanying talk and questioning, to approach the inner source of his conflicts. (Page 31.)

After several weeks of art work, symbolic patterns began to appear in Nick's pictures.

The first of these unconscious symbols did not emerge clearly until it has been repeated in several battle pictures. Only then did a recurrent cleft, made by means of two parallel saw-toothed lines, become weighted with additional meaning. Whenever Nick created one of these jagged splits in some part of a picture, he would print beside the object, the single word "crack." Then he would continue the shooting and the breaking forth of flames in the battle scene.

The clinical history of this patient leaves little doubt as to the meaning of this recurrent schism in the pattern of his life. At the age of four, his childhood world had shattered when his mother left home with a lover. So speaks, consistently, the recurrent image of the great "crack"; in one picture it divides a mountain, in another it splits a tree trunk; in a third it tears a ship apart, while in yet a fourth it shatters the steeple of the church where the bride (who is also the mother) is about to be married.

The patient did not elaborate on the meaning of these rifts. But in placing the single printed word "crack" across the life pattern of these pictures, the unconscious had spoken in no uncertain terms. (Page 86.)

. . . . . .

The second outstanding symbolic pattern that the patient developed did not emerge as swiftly and sharply as this recurrent image of the "crack." It was not until several months after he had started the art work that he began to verbalize more freely about his own problems. Then only did he begin to explain to the psychiatrist who his real "enemies" were. In two succeeding play therapy sessions he expressed hostility against "enemies." The psychiatrist reported that he threw lumps of clay fiercely at the walls, trying to hit an imaginary target. He admitted these enemies to be Hitler and Hirohito. Later in the session when asked who his own enemies could be, he replied: "They could be friends of my mother's." He then proceeded to name and describe his mother's friends. A few days later, when modeling fights between enemy

snakes and crocodiles, he repeated that his enemies were "friends of my mother. I want them out of this world."

The following week, the same subject of his mother's friends who were his "enemies," was now expressed in a picture in the art session. He told of three brothers, German sailors, who were friends of his mother. He was asked if he would like to make a picture about them. He drew a green battleship and said the three sailors were on it. Above the ship he made a

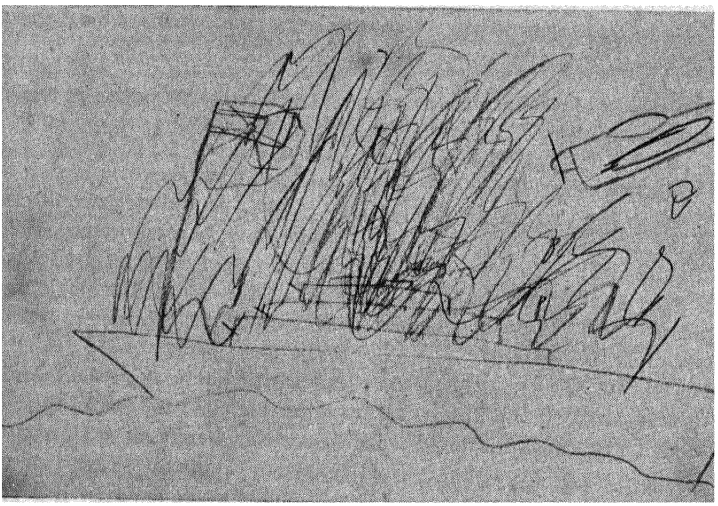

FIG. 5.—Art production of a problem boy in the course of readjustment. Explanation from Naumburg (103): Sinking the "enemy" ship containing the mother's "men friends." Designs of ships being bombed from the air by swooping planes appeared frequently in this patient's war pictures. But the symbolic meaning of this pattern only became evident after several months of art work. As the patient became able gradually to verbalize more freely, he dared to draw this picture which describes the bombing of 3 German sailors whom he called "my mother's men friends." These sailors on the green battleship are bombed by the plane which sets the ship afire with bright red flames. "Just what I'd like to do to those sailors, lay their boat six feet under. You're going to see nothing but ashes in the ocean," commented the patient. From this time on he grew gradually able to verbalize his hostility and jealousy toward the mother's lovers. (Page 46.)

plane, bombed the ship and set it afire. "Just what I'd like to do to those sailors, lay their boat six feet under. You're going to see nothing but ashes in the ocean!" (Fig. 5.)

In the fifth month of hospitalization, this patient began to be able to express openly in both play therapy and art sessions, his jealousy and resentment toward his specific "enemies," his mother's friends, whom he had destroyed so frequently before, under the guise of Japs and Germans in the battle pictures. (Pages 38–40).

In other pictures Nick gradually expressed symbolically the anxiety regarding love, marriage, birth, and sex, aroused by his traumatic experiences in the home. He expressed also, in pictures of adventure, much of the insecurity that motivated his running away from home. After five months of hospitalization, Nick was able to articulate his need for the love of his mother.

VERBALIZATION

In the preceding illustrations of emotional release a very important component of the readjustive process was represented in the verbalization of emotional feeling simultaneously with expression. When Nick was able to put his feelings in words he reflected his achievement of insight and, within a conceptual framework, his manner of dealing with emotion. As the normal individual develops from infancy, as more and more he must deal with problems conceptually, he uses symbols, principally the verbal symbols of language. Until Nick's fantasy could be transposed into language, its content had little relation to his everyday life of needs and frustrations and to his environment, pervaded as it was so ominously by his mother and her lovers.

The urge to give meaning to one's feelings through verbal expression should not be considered simply an urge to tell one's troubles to another. Rather does this urge represent the individual's attempt to deal with emotional values, just as one deals with other problems, conceptually. Until emotions can, at least to some extent, be handled conceptually their expression in behavior or in fantasy remains an autistic phenomenon misappreciated by the individual. The ability to talk out one's problems varies among individuals partly in proportion to intellectual capacity but in greater part according to the degree to which the individual feels unafraid of expression. Hence the permissive atmosphere is a vital necessity. The universality with which, in a permissive atmosphere, most individuals find emotional release through speech is exemplified in the confessional, an ancient recognition of this basic psychological principle. When their impulses are dealt with in the conceptual terms of the church, in an atmosphere of tolerance and forgiveness, full emotional expression is for many persons a possible achievement. The individual who would talk things over with a friend may feel that the friend's advice would be helpful, but often enough basic satisfaction occurs in the experience of dealing conceptually with

feelings and attitudes that, in their earlier lack of integration, were confusing and distracting and frustrating.

We have suggested that individuals are not alike in their ability to verbalize. Verbal ability is to some extent a function of general capacity; children, and adults whose mental capacity is limited, are relatively unable through verbalization alone to achieve insight. But we must consider also the individual whose meanings differ from the meanings of others, the person who verbalizes but in language that others fail to comprehend. The schizophrenic is often outstanding in his tendency to formulate emotional values into a conceptual framework, and in this elaboration verbalization is often prominent. The schizophrenic's failure is not that he is unable to verbalize, but that he is unable to utilize meanings—language—as they are employed by others. He fails to differentiate his emotion from the verbalization of it, so that he can find for it no satisfactory objective symbolization. We see, then, that verbalization as a means of achieving insight is likely to be most successful in individuals who think habitually in terms of accepted language symbols. Methods of therapy that place a premium upon verbal expression, such as psychoanalysis, are most effective with patients of relatively good mental capacity who are neurotic rather than psychotic. The less the patient is similar to the bright neurotic, *i.e.*, the greater his limitation of intellectual capacity, the more suitable are likely to be methods of expression that are nonverbal, such as art production and the primitive acting out of impulses illustrated by the case of Levy cited above. As we depart, on the other hand, from the bright neurotic toward the psychotic maladjustment, the possibility of spontaneous expression in any form becomes less likely, and the patient seems more likely to require help from the outside.

The Clinician as a Projective Device

While the cases of the two children cited above reveal certain similarities in their patterns of emotional release, there are very important differences that should be noted. It is immediately apparent that the older child, Nick, required much less stimulus to express himself in art than did the younger child to express himself toward the dolls. Moreover, while Nick was encouraged simply to make pictures, with little initial emphasis as to content, the younger child was asked immediately to associate the dolls specifically with his younger sister, himself, and his mother; he was asked

to help in modeling breasts for the mother doll and afterward provided verbally with the theme of sibling rivalry. These efforts by the examiner to control or delimit the activity of the child stand in considerable contrast to the lack of direction given to Nick. In the case of the younger child there was real interaction between the clinician and the patient. Its effect on the child was revealed very clearly in the child's desire for approval in his initial expressions toward the dolls, his questions of the examiner, his later resistance toward the clinician, refusal to play, etc. In the eighth interview the child threw parts of the doll at the clinician, explaining his action with "Because you wanted to eat me up." He struggled against the clinician when prevented in his attempt to "weewee" in the glass that contained parts of the doll. Thus, while the child's activity was directed for the most part toward the dolls, his emotional interaction with the clinician was not at all in the background. Indeed, he felt free at least momentarily to express toward the clinician an act as hostile as throwing objects at him. Nick freely engaged in conversation with the clinician regarding his pictures and other matters and even asked her to pose for one of his earlier pictures, an event significant in his progress toward insight. Comparing the two children in the degree of their interaction with the clinician, that of the younger child seems to be more direct and impulsive, though more incidental and transitory. Nick's emotional engagement with the clinician was deeper, more mature, and of greater permanence, at least over the period described. In each case, however, this patient-clinician bond was important among the factors facilitating emotional expression. Indeed, the possibility of this emotional relationship is probably most responsible for the permissive atmosphere that we earlier discussed as vital to emotional release.

We see, then, that the person of the clinician may serve—in effect as Levy's dolls served—as an object upon which emotion may be released directly. This direction of emotional release upon the clinician is an important component of the experience of readjustment, particularly in situations that provide principally for verbal expression. The clinician becomes himself a projective device. He may serve as representative of parent, the fountainhead of security and authority. He may serve as lover or loved, as enemy feared or despised. Naturally, the role attributed to the clinician by the patient varies from time to time and with the patient's apperceptive

background, his initial attitude toward the counselor, and his particular problems. A highly significant factor, of course, is the personality of the clinician in terms of the readiness with which he can be identified by the patient with persons significant in his emotional experience. According to psychoanalytic theory, the process of temporarily falling in love with the clinician—the *transference* of affection—is a step necessary in the full analysis, so that the sex of the clinician is important. While the degree to which the patient needs actually to fall in love with the clinician is highly variable, depending upon the case, it is probably true that the patient does not feel in a permissive atmosphere unless his feeling for the clinician at least during some interval is strongly positive. Certainly, to the extent that the patient in achieving insight needs to express hostility toward the clinician, it is necessary for him to be capable of a positive feeling equally as strong.

The variety of expression of positive and hostile feelings toward the clinician is naturally very great. We have seen that children are often direct and impulsive in their expressions; sometimes they openly demonstrate their affection in embraces and seek similar outward demonstration from the clinician. The child's hostility likewise may be openly expressed in active resistance, throwing things and even hitting the clinician. Among older individuals, expressions are, of course, likely to be much more refined and sometimes very subtle. Following a particularly anxious interval with the clinician, the patient may find it impossible to arrive on time for his next appointment, or he may find "unavoidable" necessity to cancel it entirely. As the patient gradually acquires insight into his basic emotional needs and the conflicts that are central to anxiety and guilt, his need for freedom of expression becomes very great. Awareness of hostility toward the clinician (as well as of strong positive feelings) sometimes intensifies feelings of guilt and so may engender temporarily an increased repression. It is the individual's awareness of these changes of feeling and expression and his adaptation to this new self-knowledge that makes self-tolerance possible and so readjustment.

Role of the Clinician in Readjustment

Up to this point we have considered the problem of readjustment almost entirely as a function of the patient, a process that involves his dissatisfaction with present adjustment, the reexperience of

anxiety, the release of emotional tension, and finally the achievement of insight and of a more successful, acceptable solution. Patients vary widely in the degree to which they may be expected to undergo this process spontaneously. Certain patients can hardly be expected autonomously to accomplish these steps in the readjustive process—they lack the capacity for insight or the motivation even to feel a need for help. On the other hand, many poorly adjusted individuals seem to possess the resources to work out their own readjustment almost without assistance. Between these extremes lie the vast majority of maladjustments that—requiring more or less outside help—may be expected at least in part to develop autonomously a more satisfactory or successful solution.

The Concept of Therapy

In this chapter we are interested primarily in the role of the clinician in the task of caring for the maladjusted and of facilitating readjustment. The traditional term applied to the clinician's tasks in this regard is *therapy*, or treatment. It may be wise for us to examine this concept, since traditionally it is associated so generally with the clinician's activity in facilitating readjustment. The term "therapy" implies quite clearly the notion of the *cure of disorder or disease.* Naturally the term is very appropriate when applied to procedures that obviously bring about recovery. The removal of a piece of shrapnel from the shoulder of a wounded man may be followed by markedly increased function of the arm, in which case the surgery involved is properly considered therapy. The use of drugs to reduce the frequency of epileptic convulsions may be considered therapeutic to the extent that such procedure accomplishes its purpose. In the area of psychopathology, however, we are on less certain ground. While there is a long tradition that maladjustments are to be considered mental diseases or disorders, we have seen that such a viewpoint does not reflect accurately the true nature of most psychopathology. It seems today more accurate to regard behavior that earlier was considered abnormal rather as reflecting solutions to anxiety that, entirely comparable in their dynamics to adjustive solutions, differ from these principally because they are incapacitating or inadequate to the practical demands of the environment. The cure for neurosis, for schizophrenia, for alcoholism—far from being specific, like a tonsillectomy—is bound to be complex, involving many and varied activities clinically, but only in a most

incidental relationship to the process really essential, *viz.*, the patient's own autonomous readjustment.

Stemming as it does from the medical tradition, the term "therapy" is applied by many, not only to procedures that presumably effect recovery, but to any procedures that are administered with the welfare of the patient in mind. Thus, in psychopathological literature, one finds reference to drug therapy, to hypnotherapy, to physiotherapy, and to hydrotherapy, more or less associating the idea of treatment with the agent administered. In the same sense, one finds that the patient's activities are encouraged in terms of occupational or recreational therapy, his meals in terms of dietary therapy, his reading in terms of bibliotherapy, and his relaxation and sleep in terms of rest therapy. When the patient is treated together with other patients, he undergoes group therapy.

From this point of view, it is clear that the term "therapy" may be applied to any administration to the patient. What is most important in this connection is the implication of *doing something to* the patient, an emphasis on the activity of the clinician (or therapist) and therefore on passive reception by the patient. Presumably, the patient recovers from his illness as a result of the active administration of therapy. Such inference is unfortunate not simply because it is invalid but because it creates, particularly in the realm of psychopathology, a logic that serves to cloud the issue. The patient who recovers from intense anxiety may indeed have profited from a change of environment, from relaxation and good food, but his readjustment, if it develops, is much more truly a matter of his working out for himself—possibly with help and understanding but perhaps in spite of these helps—some solution that is compatible with successful social adjustment.

Of all the compoundings of the term "therapy" as applied in the realm of maladjustments, probably the most important for our consideration is the term *psychotherapy*. In its broadest sense this term "psychotherapy" is sometimes used to cover all the procedures that are used in handling maladjusted individuals. In this sense psychotherapy would include shock treatments, psychosurgery, administration of drugs, hypnosis, rest, baths, etc., wherever these are intended to promote the welfare of the maladjusted individual. In a narrower sense, the term "psychotherapy" is more often restricted, however, to procedures that, on the one hand, go beyond physical manipulation or medication of the patient and, on the other, depend

primarily on the face-to-face interpersonal relationship between the clinician and the patient—*i.e.*, the clinical interview. Psychotherapy in this sense is often used together with other procedures. The epileptic patient under drug treatment is very likely to receive supplementary counsel and advice. Electric shock in the case of depression, if effective in arousing the patient, is almost certain to be followed by psychological study and guidance. The patient whose anxiety achieves final expression in the form of duodenal ulcer receives treatment, not only in terms of diet and rest, but also in the form of interviews that are aimed at elucidating the roots of his anxiety.

These criticisms of the term "therapy," essentially of its appropriateness in association with maladjustment, are insufficiently damning to eliminate its use, however; whether for good or ill, the concept historically has become definitely fixed. It is well for us to evaluate at least briefly, then, certain basic factors that—in our own language associated with the care of the maladjusted and in the facilitation of readjustment—fall traditionally in the area of therapy and particularly psychotherapy.

At the outset, it is important to stress the rather obvious fact that the clinician's procedure will depend on the nature of the maladjustment itself. Though the procedure will depend considerably more upon the dynamics of the maladjustment than upon the personality structure at the time of examination, it is nevertheless highly important to make accurate appraisal of the individual. We have seen that maladjustments characterized by psychopathic features or by defective mental capacity, because of inoptimal motivation or capacity, are unlikely to be replaced easily by adjustive solutions and that this is also true of the markedly psychotic. This does not mean that the individual of borderline mental capacity will not profit greatly from educational procedures that are adapted to his intellectual level and particularly to his individual capabilities. It means simply that in these cases in which the clinician will have to exert greater effort or make greater provision, the function of active therapy, which is essentially directive and authoritative, is the more required. Thus, the appraisal of capacity, motivation, and control —whether by test or exploration of the case history or simply by interview—is a necessary first step in determining the therapeutic procedure.

Recalling our discussion in the previous chapter concerning read-

justment, it is clear that the therapeutic approach initially will be determined at least in part by the patient's attitude in his first interviews; during these the clinician must evaluate the personality of the patient in terms of motivation and capacity and particularly in terms of the dynamic history of his present adjustment. In this early stage the patient seeking help presents much less a problem than does the maladjusted individual who feels no need. Naturally, in the latter case, the clinician's first concern is the possibility of arousing in the patient some dissatisfaction with his present inadequate solution. In considering the range of solutions from the hysteric to the schizophrenic, there was evidence that older, archaic, autistic elaborations play the more prominent part in the maladjustment as we approach the psychotic pole. Another way of looking at this fact is to consider that, as the more elaborative solutions are encountered, one also meets with greater rigidity and resistance and lesser concern or rapport with the immediate environment. The arousal of dissatisfaction with the present adjustment is a greater problem in these elaborative solutions than it is in the more extratensive, neurotic solutions. In schizophrenia, shock treatment (by means of coma induced through repeated doses of insulin) is considered an effective precursor to other forms of therapy in this initial task of arousing the patient from the refuge of his autistic world. In similar manner convulsion induced by drugs but particularly by electric shock has been described as effective in arousing the depressed patient from his morbid preoccupation, serving thus as a preliminary to study and guidance of more psychologic nature. Recently, radical surgery of the brain has been described as an effective technique, one which very likely has a similar function in forcing on the preoccupied patient an engagement with the present environment.

It is not the purpose of this book to discuss these shock methods in detail, for they are techniques essentially medical in that they involve drugs and the physical manipulation of the patient. However, they must be considered psychologically with reference to their dynamic importance in the readjustive process. It will be recalled from Chap. XII that intense traumatic experiences often seem of paramount significance in that they are followed by severe alterations in the personality pattern. It was suggested that for certain individuals the idiopathic epileptic convulsion, whether simply as an intense physiological episode or as an outlet of specific symbolic

significance, seemed to serve some function in making possible a more satisfactory adjustment. We do not know precisely why it is that the insulin coma or the convulsion induced by shock bring about a more satisfactory rapport, but the finding that in so many cases they do have this effect, and further, that such experience permits more effective clinical relationship is an important consideration wherever extreme, psychotic preoccupation is predominant.

We have seen, then, that in cases of extreme psychosis, in which the patient is too preoccupied with his elaborated world to feel essential concern for the immediate world about him, drastic shock is sometimes effective in arousing initial dissatisfaction. These drastic methods are not required in the more neurotic maladjustments, for here anxiety is more prominent in the clinical picture—it is nearer the surface. This is not to detract from the significance of anxiety in the psychogenesis of the more psychotic solutions, for, historically, frustration and anxiety are of importance in all solutions. The psychotic solutions represent more rigid barriers against anxiety; they are older and more elaborate. Less fixed, less established, less effective, the neurotic barriers are newer formulations of defense against more recent conflicts.

Where anxiety is present in the clinical picture, dissatisfaction with the present adjustment is almost automatically assured, since anxiety itself is a discomfort. Hence, one need not, in the anxiety-present solutions, feel it necessary to produce discomfort. Indeed, when anxiety is the most prominent feature—as in anxiety state—the clinician often feels that some respite from this intense state, essentially of chronic fear, is desirable, at least until the patient can achieve some insight into his present situation. Such a patient seems sometimes to be so absorbed in his very anxiety as to present almost the preoccupation of the psychotic patient. There is one real difference, however: the patient intensely anxious—in his emotional responsiveness, his distress, his perspiration, palpitation, restlessness, sleeplessness—is all too clearly upset in his *present* environment and is absorbed almost entirely in his fear of failure to meet the demands of this environment. The preoccupation of the psychotic patient is quite different; he also may exhibit intense emotionality (as is often the case with the depressed, suicidal patient), but his tension relates, not to frustrations from the present environment, but to conflicts within and of long standing.

For the intensely anxious patient the clinician may, as suggested

above, feel that some relief of anxiety is necessary if only to provide sufficient relaxation for further psychological help. In such cases sedatives may be used, often in such dosages as to provide prolonged sleep, a procedure known as *narcosis*. This enforced sleep—sometimes lasting for two or three days—was described as a useful procedure with acute reactions to combat, during the war. In these cases the patient's terror initially was so pervasive that it was impossible even to evaluate psychotic or neurotic symptomatology. Following prolonged sleep, the anxiety features were at least to some extent dissipated, and it became possible both to make more insightful evaluation of the personality and to adopt more individualized therapeutic procedure.

It can be seen that in the initial stages of the readjustive process—in arousing the patient to dissatisfaction with his present environment and to the reexperience of anxiety, the clinical procedure at least for psychotics may involve medical techniques such as shock, drugs, and even surgery. Medical procedures are not necessarily limited to these phases, however. The stages of the readjustive process that follow the reexperience of anxiety—those in which emotional expression and the achievement of insight are of greatest significance are for psychotics a possible outgrowth of the initial arousal processes. In the neurotic patient, however, anxiety is already present in some degree, and these phases of expression and achieving insight may be the starting point of the therapeutic relationship. During these phases also certain medical procedures are sometimes used, procedures such as the use of drugs to facilitate the patient's reliving of a traumatic situation or as a means of exploring areas in interview that are disguised or obliterated by repression in the waking condition. The combination of drug hypnosis with psychological interview has been widely used in recent years as an attempt to speed up the more time-consuming process of orthodox psychoanalysis. An excellent reference in this respect is the work of Grinker and Spiegel, which was done with casualities of the Army Air Forces (52).

Methods that involve medication and physical manipulation, whether drastic, like electric shock, or incidental, like the administration of pills, represent psychologically an authoritative role on the part of the clinician. He is clearly doing something to the patient, with the implication that the agent used will have some desirable effect. Psychologically these medical techniques are no

less authoritative, however, than are certain interview techniques that involve medication not at all but, given in an atmosphere of equal professional prestige, consist of advice and persuasion. As has been pointed out in earlier discussion, the clinician's first contact with the patient is very apt to be in a setting in which, whether his counsel is sought or not, he is nevertheless identified with wisdom and authority and expected to do something for the patient. The latter, often as not, is likely to be so expectant of counsel of some sort that if some authoritative advice is not given he will be disconcerted. The clinician's initial attitude is of extreme importance in establishing an optimal relationship. In an excellent discussion of this subject of initial impressions Rogers (118) suggests that obtaining from the patient the facts of his history and the administration of psychological tests must be considered as procedures that reconfirm in the mind of the patient the impression that the clinician—an authority who needs facts and figures in order to make his diagnosis—will obviously and naturally deliver his considered opinion.

It is in the stages of the readjustive process characterized by emotional release and expression and by the achievement of insight that the interpersonal, dynamic relationship between patient and clinician becomes of paramount significance; here one must, therefore, evaluate carefully the role that it is wisest to maintain. Not all attempts at therapy aim deliberately to wean the patient from the therapist. Not only in pre-Freudian days but today as well, many see no necessity for the clinician to release his authoritative role; indeed, some standard clinical texts suggest that the maintenance of the proper authoritative role is a primary advantage in dealing with most maladjusted individuals at all times, on the theory, possibly, that the clinician in this way fulfills a fundamental need of the patient. The patient comes to the specialist for authoritative advice. Another reason for this viewpoint may be the persistence of the idea that maladjustment actually represents disease or disorder, some malady of which a patient may be cured, but which is rather likely to be more or less chronic and relieved only temporarily. For the most part, the patient must be carried along by someone with his interests at heart. One hears a person characterized as a neurotic, implying that his is a life history and future of instability. Whatever may be the logic for this notion that the authoritative clinical role is a desirable end in itself, it reflects clearly a viewpoint

that is incompatible with the concept that the patient's independence is vital to his adjustment.

The gap is very broad in many cases between the patient's usual passive dependence in the early stages of the therapeutic process and the self-reliance that is its object. The task of bridging this gap is the main task of therapy and manipulated in widely different ways by clinicians. Although the lineage of descent is not always clear, almost all therapeutic methods that are structured about the relationship between clinician and patient bear some relationship to Freud, who first examined the significance of these interpersonal dynamics. While the psychoanalytic procedure has many variations in its application today, it may be considered basically as a process designed to permit the patient to achieve insight into the psychodynamics of his personality. This necessarily involves the reexperience of anxiety in association with focal conflicts. Since these focal conflicts are so often rigidly repressed and so often associated with events in the patient's long-forgotten infancy, it is rare for him to reexperience anxiety without an extended period of reflection and verbalization. Freud found that from the patient's free association of ideas, his recall of early childhood memories, his report of dream content and other fantasy, the analyst could reconstruct at least in part the dynamics of the patient's early childhood.

But this psychoanalytic procedure of encouraging the patient to recall was found to be particularly facilitated when it was seen that the analyst, in his relationship to the patient, served as symbolic of a particular figure who, in the life of the patient, was highly significant emotionally (when *transference* was effective). The emotional valence of the analyst was found to be crucial, not only in facilitating the ease of the patient's recall, but as an object—entirely similar to Levy's dolls—upon which emotional expression could be released. Conflicts and their anxiety are repressed, for the very good reason that they are intensely unpleasant. The reexperience of these unacceptable conflicts—their very recall—is possible only in an atmosphere that permits the patient to discharge his violent reaction to them.

In the psychoanalytic procedure, the analyst usually remains largely in the background, intruding upon the patient's verbalizations only when it seems necessary through direction of the association or through interpretation of a moot point to facilitate the process of achieving emotional expression and insight. The degree of such direction by the clinician varies throughout a given course

of therapy. Not only does the usual patient require greater direction initially, but as the therapy proceeds, his initiative will vary from time to time, depending on his varying resistance, his hostility or friendliness with the analyst, and so on.

In the matter of transference—the degree to which the clinician takes on emotional significance for the patient—there are wide differences among patients. We would naturally expect transference to occur most easily among extratensive, neurotic individuals, and least readily among the introverted who are inclined toward autism and inner elaboration. While psychoanalytic procedures are not necessarily hopeless with the elaborative solutions verging toward the psychotic, because of this difficulty in transference, they are here considerably less effective than they are with neurotic maladjustments. The process of achieving insight, though far from a matter strictly intellectual, nevertheless does require at least average mental capacity, so that psychoanalytic procedures are, on the whole, likely to be fruitless as one approaches levels of capacity verging on mental deficiency. Psychoanalytic procedures, like any other psychotherapeutic ones, are thus most effective with the bright-neurotic group, a group that, as suggested in the last chapter, is composed of the most favorable candidates for readjustment under any conditions.

One of the real disadvantages of orthodox psychoanalysis is that it usually requires a long course of interviews; customarily the patient spends about five hours per week with the analyst, for a period ranging from six months to as long, perhaps, as eighteen months. Obviously it is impossible for the analyst to interview more than six or eight cases concurrently; the number of individuals who can avail themselves of this form of therapy is thus distinctly limited. Because of this time prohibition, much psychotherapy given today is in the form of short-term procedures; most of these involve to a great or lesser extent the principles that were first elucidated by Freud—principles such as the transference and the gaining of insight, which, though not in themselves properly constituting a psychoanalysis, should be considered outgrowths of Freud's methods.

Among the short-term forms of therapy are certain forms that represent deliberate attempts to shorten the orthodox psychoanalytic procedure. The supplemental use of drugs to facilitate emotional expression, as in *narcoanalysis* and *narcosynthesis*, may be carried out within the frame of the psychoanalytic procedure as by Grinker and Spiegel (52). Interest in hypnosis as an adjunct to psychoanalysis has recently been renewed(21, 93).

An adaptation of psychotherapy that seems to be related to psychoanalysis in many respects but to differ from it sharply in at least one is the procedure recently described in detail by Rogers (118). This writer feels that the essence of psychotherapy is the preservation of the permissive atmosphere and that this requires of the clinician more than the customary attention to his role of nonauthority. As if to focus attention on the saliency and uniqueness of this characteristic of therapy, Rogers[1] designates the relationship between clinician and patient as the "nondirective" approach. A comparison of Rogers' procedure with those of orthodox psychoanalysis suggests that they are not essentially dissimilar in this emphasis on the nonauthoritarian role of the clinician nor in the general objectives of the therapeutic procedure. The greatest difference between these two procedures seems to be in the degree to which infantile conflicts are, in the orthodox psychoanalysis, almost invariably reexperienced at a verbal level, while in the course of Rogers' procedure no preference is given for this direction of association over any other. The effect of Rogers' procedure, in permitting the patient possibly greater freedom in the associational area of choice, might be to permit a greater retention of repression and so an avoidance of the more painful areas, which, perchance, might concern infantile sexuality. However, since successful therapy depends on the patient's final insight into truly significant areas of anxiety, it is unlikely that any procedure that in this way suppresses focal areas would achieve the end result that Rogers describes for his cases. The alternate interpretation would present itself as likely, therefore—*viz.*, that successful end result in therapy at least in many cases does not require the exploration of infantile sexuality in all its ramifications.

For the purpose of revealing the minimal extent and depth of therapeutic procedure that may be required, the following example taken from the report of nondirective interviews by Madigan (95) will illustrate the results that were possible in four sessions, one week apart. C. designates the counselor, S. the patient.

In the following case all that the therapist knew about this client, prior to counseling, was that she was sixteen years of age, of average intelligence and had experienced social case work and psychiatric services prior to her commitment to the Bureau of Juvenile Research for study.

[1] An excellent, up-to-date and efficient description of Rogers' procedure is presented in C. R. Rogers' and J. L. Wallen's *Counseling with Returned Servicemen*, McGraw-Hill Book Company, Inc., 1946.

Case of Jane—Age 16

First Interview

S. brought two photographs with her which she showed to the Psychologist who introduced us and when the latter left she said she wanted me to see them too. I commented that they were fine pictures. She explained that they were of her brother and sister and she placed them out of sight and "settled back" as if to ask what was to come next.

C. Perhaps you wonder why you were sent for this morning.[1]

S. Yeah, I'm to come over to talk with you for an interview. What do you want to know?

C. Well, this is to be a different kind of interview. It will be about what you want to tell me rather than anything that I would ask you. In other words, it will be an hour which you can use to talk about your problems—things that bother you—uh—how you feel about things—things that you may be worried about.[1]

S. (*Slight pause*). I don't know where to begin from.

C. It's hard to know where to begin.

S. (*laughs*). I don't know where to start. Uh, would you like to hear how I got in trouble?—or what's bothering me now? (*nervous giggle.*) That's right you just said I could talk about anything that was bothering me. Uh—I ran away from home—four days—the reason why is that I got pretty disgusted where I lived—I got into trouble with girls at the Court. They gave me another chance. I knew I wouldn't be good so I moved into the Center with two social workers. My sister moved in too. I got fed up. (*she tells about the bother of signing in and out, where she was going, with whom and how long she intended to be gone—whenever she went out.*) And then my boy friend—a boy I went to school with—we got a crazy idea—to get married. Well, that was before I had a chance to think it over. Then I realized that it would be crazy. He wouldn't be here long, and I knew he couldn't take me across on the boat with him—uhh—but what's really bothering me is—I want to go home and make something of myself. I want to get back into school (*words lost—tells that she was expelled from school, but they'd take her back now*). I got expelled when I got into trouble.

C. It's been rather tough going, running away from home, living at the Center, getting into trouble and then being expelled from school.

[1] By her gesture of settling back and her question, the client indicated her intention of letting the counselor carry the responsibility for the interview. Instead of drawing her out, or otherwise directing the interview, the counselor structured the counseling situation as something different from other interview experiences in which she had been questioned. Here it is her responsibility to take the initiative; to talk out what is important to her.

S. You said it! My aunt—my sister really has faith in me. Everybody *there* does. The psychiatrist there wants to work with me, the medical social worker, the Juvenile Court. Really what I want is to get back home and make something of myself. I've got diabetes—can't work very hard—but I want to get a good job, get back in school and work afterwards. My sister works. I could work after school, I could buy myself the "extras" and save her money. If I could go home to _____—well, they'd understand me and they want to help me.

C. You feel that the people there are really more understanding of you. You'd have more of a chance back there.

S. (*Agrees. Talks on that even the school principal who expelled her likes her, testified for her at Court*). If I get back home—oh—it all depends on the Court and what they say here. If I get back to _____ I'm not going to have anything to do with my old friends. You know those old friends weren't really friends. They knew what I was doing but they didn't put me back on the right track—they weren't friends. They let me go on—.

C. You feel that even your friends let you down.

S. Not "even my friends" they weren't friends at all. You know my sister and brother had it even more hard than I, but they got a year in college even. (*She goes on talking very rapidly about the good jobs her sister and brother have had and that it should really be easier for her than it was for them.*)

C. You feel that they made something of themselves and that you can do the same.

S. Yes. I've done a lot of talking but never did what I said. That's why the Judge and everybody—well, I'm here to see if I really did mean what I said (*words lost—but she talks vaguely about a diabetic coma she had which made it necessary for her to be in _____ Hospital—she launched into another vague account of a serious illness—pneumonia—her sister had—*) All the time she was delirious she talked about me—she was so worried about me. She got sick worrying about me, you see. It was my fault.

C. You feel that you had something to do with her sickness.

S. That's right.

C. That it was sort of your fault.

S. Yes—I caused my brother a lot of worry too. They've been too good to me to cause them trouble. I want to show them I can make something of myself. I want to prove it to myself too. I ought to, too.

C. You feel that you owe it to them as well as to yourself to make good.

S. (*Crying*). Not only to them—but to my aunt and uncle too. (*Tells that she disgraced them.*) The neighbors all talk about them, about me—they say, "Look at what you raised." It wasn't their fault. They did a lot for me. I just didn't think before I did those things.

C. You feel that it wasn't really fair for the neighbors to blame your aunt and uncle for what you did when it was your fault. You didn't think first.

S. Yes, I don't pity myself. I can't have my father and mother back. All I have is my brother and sister. I've got to do something for them. Why—you know (*tells about the many sacrifices her sister has made to buy her things and try to make her happy*). When she only earned $11 a week, she spent half of it on me. I've lost so much school work—for illness—two years. Maybe if I went to night school too, I could make some of it up. I live with my aunt now, I could study there. My sister moved out of the Center too. She wants me to go back to school. So does my aunt. I want to, too. I want to make up what I've lost and graduate.

C. It's awfully important to you then that you catch up on what you missed at school and then get ahead.

S. That's right. What was discouraging was that the kids wanted me to do things. I'd lay around the house. I'd want to do them, but I couldn't. I just laid around home. My aunt didn't think I was sick. She took me to the hospital. The doctors at the hospital said that there was nothing wrong with me but I knew there was. My aunt took me to a private Doctor. She found that I had diabetes. I'd be home sick the first part of the year, then about the middle the Doctor would write a certificate—in the middle of the year—that I could go back to school. (*Tells about being behind the rest of the kids.*) Of course I wouldn't pass. Then I'd have to stay behind. Two classes got ahead of me—but then, now I am glad those kids have passed. They won't be in the same class when I go back. They've passed on to Senior High. None of those kids will be at the Junior High when I go back.

C. While it was hard and embarrassing to have the kids pass on ahead of you in school, now you're glad they have.[1]

S. Yeah, I'll be with new kids (*slight pause*). My sister and Dr. _____ recommended that I *not* be sent away. Now my sister wants me real bad. (*Tells that the sister had left the Center before she had gotten into trouble—she wasn't there to take care of her.*)

C. You feel that if your sister had been at the Center when you were, you wouldn't have gotten into trouble.

S. Yeah—but she left me in the care of two social workers (*a grunt of*

[1] This response is inadequate as it does not include recognition of the various feelings Jane has expressed about her health, the failure of the doctors at the hospital, her sense of satisfaction and justification because of the diagnosis made by the private physician. The response made was confined to the client's attitudes toward school and didn't catch all of them. It is interesting to see how the client, in the next response, completes the picture by adding "I'll be with new kids."

disgust). One of them left *twenty-five cents* on a table and it disappeared. They thought I took it. Drilled and drilled me—regular third degree. One thing I did get cured of though was stealing $3.50. I cured myself. I paid it back. I don't know why I did that. I never stole like that before. I don't intend to ever do it again. I don't know what got into me that time. That is one thing that is just not in me—stealing. You know, the most important thing now though is to get back home and make something out of myself. If I were put somewhere or in a foster home—I just wouldn't care to make something of myself—I would if I were with my sister—I'd feel that I just had to—that I'd want to—that she'd want me to—

C. Your sister helps you an awful lot. She means a lot to you.[1]

S. My brother too. He has *no* police record. My sister too! Her record is clear. It makes me want to cry—to have a police record. I'll either make good or kill myself.

C. You feel that you've disgraced them by having a police record. You've just got to make good.[2]

S. Yeah, not only *them*—I've disgraced myself too. What I do now will decide my future life.

C. You think that *now* is a most important time.

S. Now and from now on—(*words lost—shifts to her health*). I couldn't always do things because of my sickness—but—lots of people have poor health but they get along, even some movie actresses have sickness but they make something of themselves.

C. Poor health has been a handicap for you but you feel that from now on it doesn't need to be.

S. (*words lost, but—an alternative to making good is life in detention homes, jails, etc.*)

C. That kind of a future doesn't seem very good to you.

S. *No.* If I can go home and make something of myself, and live with my sister . . . well, she'd do something for me. You know, she has even been looking at an accordion for me. I've always wanted one and to take music lessons. My father was a musician. My sister wants me to be happy, wants to do things for me to make me happy.

[1] A better response would have been, "You feel that while you can cure yourself of some things such as stealing, you'll have to be with your sister if you are *really* going to make good."

[2] The error in this response is one of understating or "under-reflecting." The counselor caught the attitudes but, having missed the tone or the depth of the feeling, was not able to respond to the girl's feeling that making good is as vital and important to her as life itself. The counselor's statement that Jane feels that she has disgraced her family and that she really must make good is a relatively pale and shallow reflection.

C. Your sister is even willing to get a musical instrument for you to help you be happy.[1]

S. Yes. To be honest with you, it's all my fault, what's happened to me. It's not my friends' fault, or the people in the Center. I won't blame them. I won't get into that trouble again. I won't let myself.[2]

C. You feel that it's *your* fault, what has happened to you, and that it's pretty much *up to you*—what happens to you from now on.

S. Not "pretty much up to me" it's up to me—period. (*She then talks about clothes—"you know nice clothes" that she has at home*)—things you take for granted until you have to wear the kind they do in Detention Home and here. There's another thing—I'll take better care of my things this time I'm home, if there ever is a "*this time.*"

C. You're a little doubtful that there will be a *this time.*

S. (*Chokes back tears*). I deserve to be sent away to the Girls Industrial School; I don't want to go—but—but—if I do it'll be because of what I've done.

C. You feel that if this happens you've brought it on to yourself.

S. It was because of the things *I did* (*disgustedly*).

C. You don't like yourself for having done them.

S. But—if I had kept on doing them—kept on the way I was going—well, my aunt and sister would have been crazy by now. When I had to come here—my sister and even my brother-in-law cried. He told me not to worry, that I'd always have a home. That was when I left Detention Home. When I was there, I used to cut out recipes from magazines for cakes and things that I knew they liked. They don't look good to me,

[1] This response is to the content of the girl's comments rather than to the feelings she has expressed.

[2] This response illustrates some important dynamics of non-directive therapy. As the client's attitudes and her projections of blame for her trouble on to her health, her sister, the social workers, friends, etc., have been accepted and clarified, she has become able to accept herself as the responsible agent in her behavior. She has gained significant insight into the fact that she has been blaming others and that actually she, herself, has been at fault. She now sees herself not only as a person who is responsible for her past behavior, but who is self-determining and who can now exert some self control. Another interesting phase of this response is the client's statement "to be honest with you." This is characteristic of the way many clients make corrections during the counseling process as they experience the permissiveness and the acceptance of the relationship. Being free to be dishonest or to misrepresent without censor or disapproval they are freed to be honest. They have nothing to fear. Nothing is at stake. They are not being evaluated or judged. They are being helped to understand and accept themselves. As this occurs there is almost inevitably a client-initiated "straightening things out."

because you know I can't eat them, but things that I knew they and my aunt and uncle liked. I thought that when I went home, I'd try them.

C. You've worried them a lot.[1] Now you'd like to cook nice things for them.

S. Not only cook nice things for them, do nice things for them. Oh, there are so many things that I could do for them.

C. You feel that there's a lot you could do for your folks that would be different now.

S. Yes. It makes me feel so good—sort of an inspiration to think about when I get back home—and then—I'm so down and unhappy when I think of maybe going some place else.

C. You feel either very happy, or very sad when you think of going home—or—

S. (*Interrupting*). You know I wanted to go for my punishment to—(an institution for delinquent girls). That was what I was going to tell the Judge that I'd be willing to go there and take my punishment, but then my brother asked me not to. He talked against it. He said that if I ever wanted to marry a nice fellow I wouldn't want to say that I had been there. He said that he wouldn't marry his girl if she had ever served a term there. It seems like I inherit this from my mother—she's dead, and may she rest in peace and all that, but *she was* in jail—lots of times. She went all to pieces drinking. My father got killed. They blamed her for that—and she just went from drinking to something else. I want to erase all of those memories of my mother though—when she was sober she was nice. She did sweet things; you wouldn't of wanted a nicer person.[2]

C. You'd rather remember just the nicer things about your mother, but when you are in trouble you wonder if you inherit it from her.[3]

[1] One of the most common criticisms of non-directive therapy comes in the form of joking about the frequency of the "you feel—" counselor-responses. This response illustrates the danger of not labeling or specifying a reflected feeling as such. This response, as stated, might easily be interpreted by the client as a judgment passed by the therapist. A better response might have been, "You feel that since you have worried them a great deal, you would like to do something that would please them."

[2] It is often helpful in developing sensitivity to feelings and skill in reflecting them to "pull out" from client-responses specific attitudes which have been expressed. This is a particularly interesting release for this kind of an analysis. The client's feelings here expressed are: (1) her need for punishment (2) her acquiescence to her brother's attitude toward the penal institution. For her to go there would disgrace herself and family further and spoil her chance for a good marriage. (3) Her fear of having inherited her "trouble" from her mother. (4) The suspicion or question of her mother's part in her father's death, and (5) ambivalent feelings toward her mother.

[3] The variety of feelings released in this response and the conflicts between

S. Yes, I guess I did, but I'm really glad I got stopped when I did. I'm glad I got sent here. But this isn't a punishment. It's nice here—but—uh (*pause*).

C. You feel that you need to be punished and this—being here—isn't quite a punishment.

S. That's right—*but* punishment or no punishment, I want to get back home. I'm homesick. Any *normal child* wants to go home.

C. While it's nice here, you're homesick. You think that any normal child would want to go home.

S. Yeah. What was your name? I'd like to call you by name.

C. Miss Madigan.

S. Oh, yes. Do you think I should get to go home?[1]

C. You wonder if I think that you deserve to go home.

S. Yeah. Oh there I go again—yeah—I mean Yes.

C. *You're* not sure you deserve to go home and wonder what I think about it.

S. Yes, even though I don't deserve it—me being so bad and having to be away and all, but I could go home, it would be different. I'm not just saying this, like I used to.

C. You feel that you've changed. While you used to just say things, now you mean what you say (*pause*).

S. I do mean it. When I go home I want to be put on probation. I don't want to be on probation in a way—if I slipped I'd just as soon

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them create a real problem for the therapist. Should all of the expressed feelings be reflected? If so, how can they be? If not, to how many or which ones should he respond? On what basis should the selection be made? Naturally, in this as in a less complex release the response will depend a great deal on the sensitivity and skill of the therapist. Any emphasis the client may have placed on some particular area would also be important. An ideal response would be as complete a summarization of these feelings as is possible. In this instance the counselor caught only the client's ambivalent memories of her mother—the fear of inheritance. It is interesting to note that when good rapport has been established significant feelings which have been missed or not adequately reflected reoccur until they are. Thus, usually an error of omission does not seriously impede the client's progress if the counselor remains completely permissive and strictly non-directive. Notice, for example, in the remainder of this interview the restatements of problems and attitudes just expressed which the counselor's response did not meet.

[1] Asking a direct question is often a subtle way of shifting responsibility to the counselor. As a rule it is more therapeutic if instead of answering the question by expressing opinion, giving information, etc., the counselor can respond as to any other statement of feeling. Thus, in the next two responses as Jane's uncertainty as to whether she deserves to go home and her desire to get the therapist's judgment in the matter are clarified she is able to express and accept her own deeper conviction that she does not deserve to go home.

they put me in a cell and throw the keys away. Some of the kids in D.H. were on probation (*she shudders and tells of some who were dope and drug addicts*). All kinds of kids. That's why I'd like to be a social worker or a policewoman—if I could help any kid to be good—if I can save her from some of those things—well, that's what social workers do (*Slight pause*). But if you're on probation they'll *help* you.

C. You want another chance. You think it would be safer to be on probation where you could get help.

S. Yes, if they didn't trust me, I'd even report twice a week. It's for people they don't trust, you know.

C. You think it's people who can't be trusted who are put on probation.

S. That's right. I don't want my kids to know that *their mother* was a jailbird.

C. You wouldn't want your kids to think that of you.

S. No. I know how it is to think that your mother was a jailbird.

C. It's awfully hard for you to think that about your mother.

S. That's right (*looks out of the window*). But still there are some nice things I can remember.

C. While you hate the thought of her being a jailbird, there are some nicer memories.

S. That's right, but the . . . well we're getting off the subject.

C. You feel it's getting off the subject to talk about your mother.

S. Well, only in one thing is it on the subject—her getting in jail so much—that is all that would be of interest here.

C. You feel that the only thing we would be interested in here is that she was in jail often.

S. Yes, because I've been in jail, too. I may get it from her.

C. You're worried about what effect your mother's being in jail has on you.

S. (*Cries*). That's right.

C. (*Pause*). Do you want to talk about that?

S. Well, she was good up until I was born. She never had a jail record. My brother and sister take after my father. I take after my mother—I've been in jail.

C. You feel that you take after your mother, especially now that you've been in jail.[1]

S. That's right, but I look a little like my Dad. He used to be so embarrassed by my mother. We all had to bear the shame. I know what it is. Kids and people talk about you, say your mother was a jailbird.

[1] A better response would have been "you wonder what effect having had you —had on your mother—why she began to be a jailbird after you were born—and why you take after her."

C. It was pretty hard for you as a kid to have others say that your mother was a jailbird.

S. (*Pause*). *But* I really have an urge in me to make something of myself. I'll either make something of myself or I'll be locked up and forget my family and have them forget me rather than be disgraced by me.

C. If somehow you should get into trouble again, you don't want to—

S. (*Interrupting*). I want to be good and *I'm going to be good.*

C. And you feel that that (the decision) is real progress.

S. That's right. I know as I said before that if they recommend that I'd be put into a foster home—or—uh—away from my home surroundings, I wouldn't have the same feeling of wanting to get ahead—of making something of myself, but *I'll be good.* I know now that if I get into trouble—uh if I need help, I can talk with someone. I never knew before that I could talk things over.

C. You think that if you should need help now you could talk it over with someone.

S. That's right. That's all I've got to say today—it's enough too.

C. You feel that you've said enough for today. (*The hour is practically up.*)

S. (*Sat back, looked at the notes, and said, pointing to them*). Now what are you going to do with those? What all did you write down?[1]

C. I was wondering if you would want to see them. (*Motioned to her to look at them.*) You see they are notes on what we've been saying this morning. Here is this part where we talked about—and here is—etc. I usually take notes as reminders so that before we talk again, I can read them and remind myself of what we said this time.

S. Oh, that's a good idea.

C. Perhaps you'd like to see them later, too. You may if you wish.

S. O.K. Will you bring them with you next week?

C. (*Agreed to do so*). About next week, if you'd like to come back we

[1] In regards to notes—the value of having a verbatim record of counseling interviews for the purpose of analyzing them for process is obvious. However taking notes during an interview presents a problem and sometimes conflict for some therapists. They become guilty about having the client see them take notes—and fearful of impeding the progress of the interview. Note taking is an impediment only to the extent that it bothers the counselor. A matter of fact explanation of the purpose of the notes, and sharing them with the client can be of therapeutic value. This has been borne out time and time again when working with children, as well as adults, whose previous experience with agencies has left them with a suspicious attitude toward records. One youngster having cautiously reread the notes weekly for several interviews, decided to keep notes about her own thinking on the problem. She would bring these each week to supplement those taken by the counselor so that *we* would have a complete record.

could just save this hour for you. I want you to feel that it isn't something that you have to do, but that if you want to, you can.[1]

S. Can we talk like we did this morning? Do you know if I can go home?

C. (*Not verbatim*). Yes, you can talk over your problems—anything that bothers you like you did this morning. About going home, I want to explain that I won't have anything to say about that. That is, I think you should know that—that I'm not one of the persons who will decide about where you will go from here, or how long you will stay here. I'll just be here for you and some of the others to talk things over with as we did this morning.

S. (*Indicates that she does want to come again and so an appointment was made for the following week.*)

Second Interview (*one week later*)

C. How are things going?

S. Ohhh—pretty good.

C. Just pretty good, eh?

S. (*Pause*)—I guess I haven't anything particular to say—all I could do is to answer questions.

C. You'd rather I would ask questions—so you would know more what to say.

S. Yes—what do you want to know?

C. Well Jane—uh—I only want to know what you would want to tell me. You see this time is to be yours to talk over any thing which *you* are concerned about—any problem that may be bothering you. It may be that there isn't anything that you want to discuss. That's O.K. It's just that you may if you want to.

S. Hmm—shall I tell you about the problem I'm here for?

C. If that is the one you'd like to. (*pause*) I understand that girls are sent here when someone back in their home town thinks that they are problems or have problems. It's really what you think is the problem that matters most.

[1] While the counselor had been able to utilize non-directive counseling during this hour it seemed advisable to structure situation again to emphasize that voluntary participation by the client is essential. If she chooses to come again she is assuming some responsibility for the next interview. She is also having the experience of making a decision, which can be strengthening in itself. In Jane's response the question "Do you know if I can go home?" brings out a weakness in the original structuring. It would have been better had the counselor defined her own role more clearly in the beginning. It would have eliminated any need for Jane to try to make a favorable impression, or to win over the counselor to her way of thinking. Subsequent interviews indicate that this did not happen but it could easily have.

S. Well what used to be my biggest problem was to become a good girl. I know now that I don't have to become a good girl—I already have. Maybe this isn't anything to talk about—but I'd like to get me a nice job after school and earn my own money and learn how to spend it and how to save some—to learn the value of money. I never did that before when I was home. But that's what I want to do the next time.

C. You feel that one advantage of getting home again would be to get a job and learn how to handle money.

S. Yeah. I forgot your name again.

C. Miss Madigan.

S. Miss Madigan, I want to ask you a question. Do you think it is wrong for me to be getting letters from my boy friend?

C. You wonder what I think about that. Does it really matter what I think about it—what do you think?

S. (*Laughs*) That's the trouble with me—I use my own judgment too much.

C. You feel you shouldn't trust your own judgment so much.

S. It gets me into trouble. Well (*tells about 2 letters from him, etc.*) He means a lot to me but not that much—that I would want him to get me into trouble if I shouldn't be writing or hearing from him. My sister thinks a lot of him too. He's a perfect gentleman. He doesn't smoke or swear—he's clean-cut (*words lost—but she inquires again if I think she should be corresponding with him*).

C. You'd like for me to decide that for you.

S. Yes. I don't think I have had enough opportunity to know what is right.

C. You're afraid that you aren't able to decide for yourself what is right.

S. No. Well why won't you tell me?

C. If I told you what I think—it still wouldn't be what you think, perhaps, and then it really wouldn't be satisfactory for you. I think one has to decide a thing like that for herself, according to her own thinking.

S. Well, since I'm here I think it is all right to have a boy friend but that I shouldn't get too serious with him. I mean it's all right to have one and to go to shows with him and stop and get something to eat—and then go *home*—that kind of a date—but not see him every day and every night.

C. You think it's all right for you to have a boy friend if you don't see too much of him.

S. That's right! But as I said before, I think *lots of him*—but not enough to keep me from going home. I do think a lot of him. He's a nice boy—but that's as far as it goes. But I miss home *so much*. Sometimes I cry myself to sleep at night thinking about home. I like him but if—well maybe—if it weren't for him, I would be at home.

C. You like him very much but think he may have something to do with your being here and not getting to go home.

S. Yes, he was in a way. If it'd not been for him—I wouldn't have stayed away from home—he was on furlough. We planned to get married —until I had sense enough to think it over. I don't know—he really wanted to marry me—and I wanted to marry him. I wish he hadn't been home on furlough then we wouldn't have wanted to do that and I would not be here.

C. You feel that if he hadn't been home on furlough in the first place that idea wouldn't have come up—and you would still be home.

S. That's right. I'm not boy-crazy like some other girls my age. I think a girl should go around with fellows—but in a crowd of kids. There'll be plenty of time when one is eighteen or nineteen to go steady and then think about getting married. What I need now—I'm only sixteen, is to settle down and stop this getting in trouble and become something worth while.

C. You feel that the big problem right now is to be a good girl and make something of yourself.

S. That's right—that's just what I think. I have a letter from him. I'd like for you to read it and see if you don't think he's a fine boy.

C. You'd like for me to read this letter and judge him for you.

S. That's right. And whether I should keep on writing to him and let him write to me.

C. You'd like for me to decide that for you. You're not sure what you think about it and think if I'd read the letter it would help.

S. Yes, it would. I got that letter before I came up here. He's on a submarine. He's even been promoted already. He's overseas! I had to sneak that letter in. I hid it when they put my things away. I shouldn't have done it. But I wanted to be able to read it. I don't think they'll find it.

C. You're pretty proud of your boy friend for getting promoted so rapidly, and feel pretty guilty about having the letter with you here.

S. That's right. Well, if you don't want to read the letter—well, that's all I have to talk about, anyway—my boy friend and whether you think I should write to him.

C. You feel that if I don't tell you whether or not you should write to your boy friend—or don't read his letter—there isn't any more you want to talk about.

S. Oh, I don't mean that. Well, I did in a way. Of course, I want to write to him and receive letters from him—but I want to get out of this place too. I want to go home and if his letters will get me into more trouble I'll give him up. I want you to know that I'm not like some of these other girls—I don't just have to have a boy friend—some of them are kept here because they do have boy friends.

C. You feel that if having boy friends is what keeps girls here, you're willing to give him up. You want me to know that.

S. I want you to see what a nice letter he can write. It's not mushy. I do so want to go home. I pray for the best. I've had my physical examination already. That means that they must be about ready for me to leave. I'll be sent back to Detention Home from here. If I had to go to GIS—well, I'd be so discouraged. The thing I want—the only place I really want to go is back to my sister. There I know I'll be good. There won't be any reason to try to be good if I'm not there with her.

C. You don't see much point in trying to be good, if you can't be with your sister.

S. I wouldn't have any urge to change. They may send me somewhere else. They ought to realize though that I'd be better off with her and would be better able to keep out of trouble.

C. You think it makes sense that you'd be better with her—and that they ought to be able to see it.

S. Yes. I know I've done a lot of things. I deserve whatever they do to me. But anyway, I've had all of my vacation plans spoiled by being here. They ought to decide what they want to do with me. If it is to go home, they should let me know, so I could have a vacation with my relatives. Just staying here and waiting and nothing happening gets tiresome. They needn't think I'm just going to sit around here a long time and wait for them to decide. They've had enough time already. Just sitting here doesn't get anybody anywhere.

C. You feel that having to sit around here is getting to be too much of a good thing.

S. No, not exactly. I wanted to come here in the first place. They asked me if I wanted to. I said yes if they thought it would help me. It isn't as if I have some disease of the mind—or were feebleminded. It's helped me being here and thinking things over. But thinking of home—I could just go crazy. I can't stand being away from my sister. I don't know why. If you want to make something of yourself—you should do it at home. My home isn't so bad. My aunt is the sweetest thing. She's nice to me *(slight pause)*. I just feel worlds away from everybody here.

C. You feel that while your decision to come here was a good one—being here has helped—the best thing that could happen now is to get home where you could make something of yourself.

S. That's just it. You know if they want to send me to GIS and ruin my life that's up to them. From the stories I've heard about that place, I'd rather die than go there. GIS is for girls who are going to have babies. I just started to make a mess of my life. They caught me in time. Now I'd like the opportunity to go home.

C. You feel it's up to them now. They could either help you by letting you go home—or ruin your life by sending you to GIS.

S. Yes. The girls here are pretty bad (*tells of some of their misdemeanors*). I hate to think what they'd be there. I'm not as bad as some of these here even—in fact I'm really good—when I see what they've done.

C. Compared with others and what they've done, you feel you've hardly been in trouble.

S. Well, I wouldn't say that. I've been in some pretty bad trouble. But compared with them—it's been minor. But another difference is I want to make amends—but I can't while I'm cooped up here. If I could go home I could—in fact, I'm counting on it.

C. You feel that you want to make amends for what you've done and that you'll have to be home to do that.

S. If these people could only understand that. If I'd failed all of the tests the doctor gave me, then she'd know there was something wrong with me. It isn't as if I had committed murder. I've hurt my sister terribly though. It's just as if I had put a knife in her heart. I've done other things too—but that's the worst. I feel worse about that.

C. Compared with other things, you feel that hurting your sister is the worst. That hurts you most, too.

S. Yes, and I want to prove to her that I'm sorry and that I can be different. The girls in the cottage talk about smoking and drinking. Sure, I know they're fun. I've done them too. I want to have fun—but not that kind anymore. Where you have to sneak away with kids and get into all kinds of trouble. I want to have fun—but the kind you can do with older people too—and not have to be ashamed of.

C. You feel that you'd like to have a different kind of fun now.

S. In a certain sense—there has to be a limit to fun. I never used to know that. I'm going to tell my uncle not to spare the rod any more. If I need a whipping I want it—if I have to give it to myself.

C. You feel that if you need a whipping you want your uncle to give it to you—that it's important to be punished when you deserve it.

S. It sure is. I won't need it any more though. I've changed so much that I'll never need a whipping again. I needed them before and didn't get them. *Now* I won't need them.

C. You feel that you've changed a great deal in that respect.

S. I know one thing—if they send me away I won't try as hard to be good. I don't want to be a jailbird. I know I did wrong—I deserve to be punished—but I'm different. If I were like I was before then they should send me there. If I could only talk to them like I do to you and explain how I feel about things—maybe they'd understand me like you do. I've had three or four chances to run off but I didn't take them. In the beginning I wanted to but didn't have my own insulin. Now—I work in the hospital and could get it and go, but I'd rather stay and face what's

coming to me. If I did run and got caught—I'd just get packed off to jail somewhere and then there'd be no chance. I don't want to leave here that way.

C. Even though you feel they don't really understand how you feel about things, you'd rather stay and take your medicine and leave right.

S. Yes. It'd be keeping me away from home longer in the end anyway.

C. You feel you'd just be hurting yourself to run away.

S. You see I've never had a chance to talk like this to anyone back home. The judge, or the social worker, or the police woman. They all had so much to do. I guess they—

C. You feel that if you had had the chance to talk with somebody back home like you have to me, things would be different.

S. They sure would. I never had a chance at court to talk to anyone. Of course, I did pull some raw things—those two social workers gave me a pain where a pill couldn't reach. Do you think it was right that every minute they check up on you? Gosh—in spite of all that and making me toe the mark, I found plenty of chance and time to get into trouble.

C. You feel all of that checking up was rather useless.

S. Well—I do need checking up on—but not that kind. I've done some awful raw things in my time that had to be checked.

C. You feel that you have done some pretty bad things which would make it necessary to be checked up on.

S. (*Grins*). They had to.

C. You made it necessary for them to.

S. (*Grins*). Yes, some pretty raw things—

C. (*Pause*). Do you want to talk about that?

S. You mean what I did—you mean about smoking and drinking, stealing automobiles, driving away in cars without licenses on them, and staying out all night with boys and going to those night clubs. No, I don't want to talk about that. I'll make amends though. I really mean it. That's why I want to go home so badly—so I can.

C. You feel that you must be back home to make amends.

S. I wouldn't mind going to report to the probation worker. I'd be doing the right thing so it would be all right. Gee, I wish they'd tell me.

C. It's hard to just wait and not know what's going to happen to you.

S. I know even the Court back home hasn't the trust in me that my family has. I've been trying to practice being good here so they could see that I really mean it.

C. You feel that your record here will help convince them that you mean business.

S. Yes. I try hard. I've been getting along nicer with the matrons and the children. They trust me now.

C. You feel that you've won their confidence.

S. One matron in particular. She has helped me. She is really like a mother.

C. You feel she treats you like a mother would.

S. No, she doesn't—but she talks to me and explains things to me and knows what I need.

C. You find that she understands you pretty well.

S. Are you a social worker? Do you go to college? Social workers—well some of them—are human. But instead of putting faith in a child and then seeing if the faith is deserved—they just don't. At least that's the way I feel about it.

C. You feel the social workers you've known haven't put faith in you. You wonder if I'm a social worker.

S. Well, I do know that you put faith in me. Miss _____ did too. (*Yawns and apologizes—saying she stayed up late because of a picnic.*) I work in the hospital now. I like that work. That was sort of a promotion.

C. One reason you like the hospital work is because you earned the chance to work there.

S. Yes. That's one step—I'll keep on until I prove myself (*pause*). Gee, I never knew that I could talk the way I have today—well the way I did last week too (*laughs*). You're really good—here I talk to you only twice and you have my whole history practically. I've told you all of my troubles and how I feel about things—I didn't know how I felt about them myself before. You haven't asked one question—I guess you haven't had to. I've just told you everything *I* wanted to. Gee, I feel good (*stretch and yawns*).[1]

C. You find it's been a new kind of experience to talk this way with someone.

S. I wish I'd known you last year—if I could have told you how I felt about things then—oh well I have now. You know my sister and brother are nice. I'm the black sheep in the family. Seems like there is always a black sheep in every family—but I feel now that I don't have to be.

C. You feel that you have been the black sheep—but that now you can change your color.

S. (*Laughs*). Gee—it makes me homesick just to think about it. (*The time is up—she notices*).

[1] This and the following response are really choice illustrations of how valuable this uniquely different type of relationship has been for this client. Jane is right. Without any questioning or probing or history taking, she has revealed herself and those phases in her family and personal history which have significance for her. She has shown, as no one else could, the relationship between her background and experience and her behavior. As she is gaining insight into the meaning her "history" has for her, she is becoming less at its mercy and more of an independent, self-propelling person.

C. How do you want it for next week?

S. I hope I won't be here next week, but if I am I'll come over to see you.

C. You'd rather just not be here, even.

S. They're trying to hurry me out because of my diabetes. That's all right with me.

Third Interview (one week later)

S. I was sick all of last week.

C. Well I'm sorry to hear that, Jane. Do you feel better now?

S. Yes (*tells of trouble—cold, etc.*). I don't know yet what they're going to do with me. They haven't staffed my case yet. They probably—well they might let me go home if I went over and told them all the way I feel about things. I don't want to do that—have to be begging to go home.

C. You feel that you don't want to have to do that.

S. Well they probably know—but when they want to tell me that will be all right. Now some of the kids would have been over there bothering them constantly to find out.

C. You feel it isn't worth bothering people to find out. (*pause.*) You don't want to be a bothering kind of person.

S. That's right. Here's them letters. Two are from my sister and one from my boy friend and one from my brother.

C. *Reads them. She hands C. the one from the boy friend last.*

S. Now—is that a bad letter?

C. What do you think about it?

S. Well—I've got a whole lot worse. But he really was a good boy. Sometimes when we would be going out—he'd invite my sister or my aunt to go with us—now if he wasn't good do you think he'd do that? I don't.

C. You feel that that's a sign that he is a good boy.

S. He doesn't swear.

C. You feel that he really respects you.

S. Yes, I *like* him well enough but I don't want to go and get married. Some of the kids here are so silly. One girl nineteen fell in love with a boy fourteen. There are several others who do the silliest things. Now I see and realize how dumb I used to act at home when I see how she acts. I never was like that though. One of them got hysterical.

C. When you see how these kids act, you understand yourself better—how you used to be.

S. That's right. One thing I can say is I'm proud of myself since I've been here—well the last few weeks anyway. I've got a lot of faith and trust in God and if it's best for me, I'll get home. There'll be a change in me.

C. You're pretty proud of the change that has taken place since you've been here.

S. One real inspiration I had—my sister wrote that she was proud of me. She'll have a lot more reason to be when I prove myself to her. I'll have to get home though to do that. Have to have a chance.

C. You feel that the only way to prove that you are sincere is to get a chance to do so, at home.

S. Yes, since I've been here I've had so many chances to run. It's not in me now. I don't get mad here like I used to. It seems as if God has put a new heart in me or something. When I see other kids up here, I'm so proud of what I am—what I've become. (*Tells of another girl*)—the only one I feel sorry for—whose father and mother are in jail and she is headed that way—I wish my aunt could adopt her and make it nicer so she could have a chance. Uh—uh (*Pause*).

You know my mother was in jail for many years. I told you that. I thought for a long while that I may have inherited some of that stuff from her. I thought I took after her and my brother and sister took after my dad. I did take after her. I've been in jail and Detention Home—which is really a jail too, and here. I'm sort of a jailbird too. I mean I used to be. I'm not now. I've thought a lot about that too. I mean I used to—since I told you—I don't think *now* that I inherited it. Maybe I did but that doesn't matter. Now I feel *that that was her life.* She lived there *for years and died in jail even*—but that was her life. I can make something different out of mine. I don't have to be a jailbird just because my mother was one. I thought I would just become one—*but I don't have to. I'm not going to either.*

C. You are determined to make a different kind of life for yourself—.

S. (*Interrupting*). I certainly am. *I can too.*

C. You're *dead sure* of that. You know now that *you don't have to be a jailbird like your mother.*

S. That's right, Miss Madigan. And *you know it too.* I'm going to prove it, too. I don't have to have that kind of a life just because she did—even if I do take after her—she's dead and buried and she can't have any influence on me now. I'm *not* going to follow in her tracks. I've tried that out—I've had enough of that kind of life—people always locking doors behind you. Having to be with girls like they have here and had at Detention Home. Being here has made a lot of difference in me. I've had a chance to think things over and to talk them over with you too. You know what some of these other kids back home need most—but they'd probably not admit it, is to come down here and do this same thing. And then they'd feel different too (*Jane relaxes completely and continues right on talking*). I know I did wrong and I was willing to be punished. I've been away for almost three months now. I think that's punishment enough. I'm really a different person and

when I go home it will be different too—I mean I'll see it different because I'm different. When you're away from home this long—you appreciate what it was and how nice it can be (*tells about aunt, how she tormented her aunt, etc. but that she was a good sport. Continues right on about her uncle and his visiting her in D.H.*). He said he'd try to get me out if I promised to be good. I told him then that I'd rather go to Columbus and face it. I hadn't been able to be good before when I had promised him and my aunt I would be. He said that he'd take me back when I could come. He cried and cried. They really want me (*continues to talk about her dog, bicycle, etc.—stops with a deep sigh.*)

C. You like those happy memories of home.

S. I sure do and I'm confident that I'll get there some day. I don't want to brag—but I do have the most sense of any kid here. Ever since my parents were dead I've been getting in and out of trouble.

C. You feel that your parents' dying had something to do with that.

S. Yes, I would have been disciplined more if my father had lived. He would have just used the slipper. He never would have let me get by. He'd have taken a lot out of me.

C. You feel that your father would have corrected you and disciplined you and that would have prevented some of the trouble.

S. I should say it would. I wouldn't have ever known there was such a place as a Detention Home (*tells of having fooled relatives ever since she was little—truancy, etc. When her aunt and uncle would decide to punish her the other would interfere and she learned just how to work them*). One time when my aunt sheltered me I asked her to tell my uncle that I had done wrong and that I didn't know why but that I needed to be stopped. They laughed, but my uncle did beat me that time. I was glad and it did some good.

C. You feel when he actually punished you it was a help.

S. Yes. It makes me glad in my whole insides to have a good family. They trust me. You know when I was making money—uncleanly—they found out about it. They felt bad—but they said I could be better. They said I didn't have to be like that. They stuck up for me.

C. That gives you self-confidence to have them trust you and know that you can be a different kind of girl.

S. That's right. My brother's been awfully nice too. He's giving his time in the army. I think that he doesn't complain although it means he must be away from home too.

C. You look at being here as sort of being in the army—away from home for a while.

S. That's right. I've thought of running away—but that would just take me farther away from home in the long run. If I can't leave by the front door and enter my own home by the front door, too, I don't deserve the chance to go home. (*She changes the subject to social workers and*

policewomen). They never encouraged me—they'd say "what do you think." (*She talks on about the horrors of the Detention Home—the awful kids, etc.*) One girl—9 years old—had syphilis and had to go to the County Jail. I tell you if I ever get married and have kids—I'll raise them so they won't even know there are such things as syphilis and Detention Homes.

C. You want your kids to have a different kind of life too. You're going to take good care of your kids.

S. I'll either be able to take good care of them and see that they don't get into trouble—or not have them. Detention Homes and I are enemies. We'll stay that way. I wouldn't want them to ever know I was there. Oh well—I will have forgotten it by then, too. It'll be all out of my system (*sighs*). Well—you know I certainly feel *clean* now—I feel like I'm cleaned all out now—clear down inside. I felt clean last week too—but even cleaner now. Gee—I feel swell.

(*The time is up—so we decide on time of next interview.*)

Excerpts from the 4th Interview (one week later)

S. (*Tells of sister's visit—very happy about seeing her and that her sister was proud of her and had been able to say, "Jane, you've changed so—you never used to think this way about things"*). My officer told me that she hoped I would get to go home—She sees things like I do—the way I do *now*, I should say. I feel so much cleaner, Miss Madigan, now that all the stuff we talked about is out of my system. . . .

I have a lot more will power now. I used to bite my nails clear off. I decided to stop and I have. I just thought I'd test myself. . . .

When my sister left, she cried and cried. She hated to leave me here. I surely felt like crying too, but I decided that wouldn't help matters. . . .

Even though I wanted to cry *I controlled myself*. That made me feel kind of good at a time when I felt so bad. She didn't want to cry. She tried not to—but *she* couldn't control her tears. . . .

She brought me a letter from my boy friend. I told her to write back to him and tell him not to get too serious but if we were in love when we get older we could talk about getting married then. . . .

He asked me (*in the letter*), if it were true that I was in jail. He had heard it and hoped it wasn't true. My sister said she wouldn't tell him I was here if she were me. I don't feel that way about it. I'm glad I got to come here. If I hadn't been caught and hadn't had this chance to think things out and talk to you like we have—why God knows what trouble I might have been in. Now, I can be a real decent woman and get married and have kids and not have them get into trouble like I did. Why, why should I tell him I wasn't here? You know if any of those kids in _____ ask me if I was here—I'm just going to tell them that I was and that if they have any sense, they'd come down too. . . .

I'd like to be a social worker--or a policewoman. If I could help any of those other poor girls to get on the right track I sure would like to. They're funny people in a way—they would have to have a soft spot in their hearts somewhere or they wouldn't be social workers—but sometimes you never see it. I don't know though—sometimes you have to be tough with kids to be good to them. It was good for me that they got tough. You know, Miss Madigan, I oughtn't to be conceited but I've a feeling that I've changed into another person,—*I've changed way down deep.* I think God has helped me too. I couldn't have changed this much if God hadn't helped me. The first thing I do when I get out of here is to go to Church and thank God. Not that I haven't thanked Him here—I just feel so close to God now, I feel good and clean and that I can be close to Him.

Just talking these things over with you—being able to get them all off my mind has helped, too. It's a good idea to have talks like these. I wish all of the kids here could talk to you. You know it's different. When you come over to talk to the other people who work here—you always have to watch out that you don't spill the beans. I've been telling the kids to ask to talk to you. Some of them said they'd like to change like I have.

I hoped and prayed I'll get to go home. But if I don't—well—I'll just have to make the best of it. I'm going to be a good girl though no matter where they send me. It may be a while before I get to go home to live—but I'll make it. I'll prove that I'm worthy of it.

Can I write to you and tell you what happens to me when I leave here?

The counseling ends on this note: that the Counselor will be glad to hear from her. As she was not sure when she would be leaving we left it that if she were still at the Bureau and ever wished to see me on Fridays, she could leave word. She was there about two weeks longer—but did not request another interview.

Summary

Counseling has been a real-life growth experience for this girl. Through the insights gained from the release and clarification of her feelings she has grown in self-understanding, self-confidence and self-determination.

The case material just presented illustrates the dynamics of non-directive psychotherapy. Within four interviews, this client has presented her problem and released her feelings which were accepted, reflected and clarified. Jane gained insights into what, for her, were the component factors of her problem. She was then able to move forward and project goals, and methods of attaining them, which were in keeping with her new concept of herself as a socially acceptable and responsible person. (Pages 38–52.)

Summary of the Clinician's Role

In the foregoing discussion of readjustment no rigid position has been taken with regard to therapeutic theory and procedure. Principally has it been urged that the clinician's activity in promoting the welfare of the patient, when it is more than custodial, must in the long run be adapted to the nature of the maladjustment and its dynamics. It may be well to present in summary certain basic points in this regard that might in any case be kept in mind.

First, the educative or therapeutic procedure will require always a careful initial appraisal of the personality. Not only must the clinician determine for himself the facts required for accurate diagnosis, but he must construct for himself some hypothesis to explain the patient's present situation. What is the patient seeking? How does his present solution, inadequate though it may be, serve as a satisfaction?

Secondly, one will in all cases want to be sure that the physical health of the patient receives proper evaluation and, if necessary, treatment. This was discussed in Chap. V.

A third very important consideration is the possibility that the patient's adjustment is such as to constitute a potential danger to himself or to others. In cases where there is even suggestion of psychosis or of depression, the possibility of suicidal attempt or of delusionally determined hostile reaction toward others must always be considered. Patients whose behavior reveals psychotic trends should never be left alone except under conditions of the greatest precaution against the possibility of violence.

The three considerations just presented constitute a basic program in any case, for they relate to the care with which the clinician approaches the problem and discharges his fundamental responsibility. These phases of the clinician's role can hardly be considered actively therapeutic (although any behavior by the clinician in carrying out these responsibilities may have a constructive, therapeutic effect).

The fourth general consideration is that the clinician will want to provide for the patient within practical limits the optimal environmental situation for subsequent study. It is obvious that where psychosis is suspected, custodial care or institutionalization might well be a primary consideration. But in cases well within the nonpsychotic range of maladjustments, the clinician is sometimes in a

position easily to effect gross changes that facilitate further study and therapeutic attempts. Possibly the child having difficulty in school would profit by a simple shift in room placement—at least this might seem to be worth the experiment. In the case of the problem child, observation for a period in another home situation or even in a group organized for purposes of social study might reduce certain frustration and so promote clinical appraisal. With an occasional child, the summer camp or even boarding school might seem to be a healthy change of environment.

The fifth general consideration would involve the procedures that are essentially clinical and directed intentionally toward the therapeutic goal. Possibly an initial suggestion would be that the clinician consider himself primarily in the role of catalyst to the patient's own readjustive process. In this sense he would provide direction to the patient as little as necessary but also as much as necessary. It is the clinician's primary obligation to set the course, to establish procedure, even though his objective may be to let the patient, within this frame of reference, eventuate his own choice of solution. The clinician may decide on a relatively short course of procedure, or he may establish a procedure that explores carefully the history. No matter how long or short the course of procedure determined upon, the clinician, in his basic task of facilitating readjustment, will handle with particular care the factor of transference. In the longer procedures such as psychoanalysis, procedures in which the transference is of vital importance, the emotional significance of the clinician to the patient is very great. But the objective, here and in all other therapeutic relationships, is to wean the patient from his emotional dependence on the clinician and on all others, through a process whereby, in coming gradually to understand himself and his strengths and weaknesses, the patient—the individual—is free.

APPENDIX

NOMENCLATURE OF MENTAL DISORDERS ADOPTED BY THE AMERICAN PSYCHIATRIC ASSOCIATION, 1933 (4)

Psychoses with syphilitic meningo-encephalitis (general paresis).
Psychoses with other forms of syphilis of the central nervous system.
  Meningo-vascular type (cerebral syphilis).
  With intracranial gumma.
  Other types (to be specified).
Psychoses with epidemic encephalitis.
Psychoses with other infectious diseases.
  With tuberculous meningitis.
  With meningitis (unspecified).
  With acute chorea (Sydenham's).
  With other infectious disease (to be specified).
  Post-infectious psychoses (infection to be specified).
Alcoholic psychoses.
  Pathological intoxication.
  Delirium tremens.
  Korsakow's psychosis.
  Acute hallucinosis.
  Other types (to be specified).
Psychoses due to drugs or other exogenous poisons.
  Due to metals (to be specified).
  Due to gases (to be specified).
  Due to opium and derivatives.
  Due to other drugs (to be specified).
Traumatic psychoses
  Traumatic delirium.
  Post-traumatic personality disorders.
  Post-traumatic mental deterioration.
  Other types (to be specified).
Psychoses with cerebral arteriosclerosis.
Psychoses with other disturbances of circulation.
  With cerebral embolism.
  With cardio-renal disease.
  Other types (to be specified).
Psychoses with convulsive disorders (epilepsy).
  Epileptic deterioration.
  Epileptic clouded states.
  Other epileptic types.

Senile psychoses.
  Simple deterioration.
  Presbyophrenic type.
  Delirious and confused types.
  Depressed and agitated types.
  Paranoid types.
Involutional psychoses.
  Melancholia.
  Paranoid types.
  Other types (to be specified).
Psychoses due to other metabolic, etc., diseases.
  With diseases of the endocrine glands (to be specified).
  Exhaustion delirium.
  Alzheimer's disease.
  With pellagra.
  Other somatic diseases (to be specified).
Psychoses due to new growth.
  With intracranial neoplasms.
  With other neoplasms (to be specified).
Psychoses associated with organic changes of the nervous system.
  With multiple sclerosis.
  With paralysis agitans.
  With Huntington's Chorea.
  With other brain or nervous diseases (to be specified).
Psychoneuroses
  Hysteria (anxiety hysteria, conversion hysteria, and subgroups).
  Psychasthenia or compulsive states (and subgroups).
  Neurasthenia.
  Hypochondriasis.
  Reactive depression (simple situational reaction, others).
  Anxiety state.
  Mixed psychoneurosis.
Manic-depressive psychoses.
  Manic type.
  Depressive type.
  Circular type.
  Mixed type.
  Perplexed type.
  Stuporous type.
  Other types.
Dementia praecox (schizophrenia).
  Simple type.
  Hebephrenic type.
  Catatonic type.
  Paranoid type.
  Other types.
Paranoia and paranoid conditions.
  Paranoia.

Paranoid conditions.
Psychoses with psychopathic personality.
Psychoses with mental deficiency.
Undiagnosed psychoses.
Without psychoses.
Epilepsy.
Alcoholism.
Drug addiction.
Mental deficiency.
Disorders of personality due to epidemic encephalitis.
Psychopathic personality.
With pathological sexuality.
With pathological emotionality.
With asocial or amoral trends.
Mixed types.
Primary behavior disorders.
Simple adult maladjustment.
Primary behavior disorders in children
Habit disturbance.
Conduct disturbance.
Neurotic traits.

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LIST OF VISUAL AIDS

The following list of visual aids can be used to supplement some of the material in this book. These films can be obtained from the producer or distributor listed with each title. (The addresses of these producers and distributors are given at the end of the bibliography.) In many cases these films can also be obtained from your local film library or local film distributor; also, many universities have large film libraries from which these films can be borrowed.

The Army and Navy have produced a number of excellent films that can be used with this book. Consult your nearest Army or Navy training-film library for further information about the subjects that are available for public use.

The running time (min) and whether it is silent (si) or sound (sd) are listed with each title. All those not listed as color (c) are black and white. All motion pictures are 16mm.

Each film has been listed once in connection with the chapter to which it is most applicable. However, in many cases the film might be used advantageously in connection with other chapters.

In some cases the title adequately describes the material in the film; in other cases a brief description is given with the title.

CHAP. IV—APPROACH TO PATIENT

Psychological Implications of Behavior during the Clinical Visit (NYU 20min si). Shows how important clues to a child's emotional attitudes can be seen from its overt behavior during clinical visit; contrasts behavior of several children awaiting examination, during physical and dental examinations, I.Q. testing, and at play.

CHAP. VI—APPRAISAL OF CAPACITY: I. METHODS OF STUDY

Measurement of Intelligence (College Film Center 15min sd). Demonstrates administration of Stanford-Binet Scale to the thirteen-year-old boy.

Testing the I.Q. (Warden and Gilbert 13min si). Shows administration of form *L* to a five-year-old child; nature of test materials; scoring standards and calculation of the I.Q.

Performance Testing (Minn 34min si). Shows use of standard performance tests in examining both normal and feeble-minded children.

Motor Aptitude Tests and Assembly Work (PCR 19min si). Demonstrates use of seven tests of motor aptitude with college subjects possessing mediocre and exceptional abilities; compares assembly work.

Chap. VII—Appraisal of Capacity: II. Inadequacies of Capacity

Genetic Development of Children with Birth Lesions (Vineland 17min si). Outlines photographically the course of development of children with cerebral birth lesions; shows retardation of motor development in three youngsters.

Behavior of the Feeble-minded (Stoelting 10min si). Contrasts performance of two normal and two feeble-minded subjects on the Healy and Fernald Block-assembly Test.

Impairment of Abstract Behavior Manifested in Test Performance (Tufts 15min si C). Shows use of Kohs model for detecting impairment of abstract behavior in patients suffering from disturbances of cortical function.

Some Aspects of Feeble-mindedness (Minn 75min si). Modern institutional care of mental defectives at Faribault School and Colony.

The Least of These (NJ 15min si C). Presents historical changes in attitude toward feeble-mindedness; subtly portrays inmates' position in modern feeble-minded colony.

The Feeble-minded (Minn 60min si). Treats subject of feeble-mindedness from standpoint of pathology; mentions possible organic conditions causing feeble-mindedness; shows difference between morons, imbeciles, and idiots; describes eight major pathology groups.

Deficiency in Finger Schema—Agnosia and Acalculia (PCR 11min si). Describes deficiencies in counting and localizing the fingers by some feeble-minded boys.

The Differentiation of Aphasia from Mental Deficiency in Children (Mitrano 12min si). Compares aphasic child with a feeble-minded youngster; shows discrepancies between verbal and manipulation tests and between language development and social competence.

Mental Defectives—Glandular Types (Rutgers 15min si C). Lower grade Mongolians and cretins; characteristics and physical development.

CHAP. XI—APPRAISAL OF CONTROL: II. ANXIETY AND ITS SOLUTIONS

Athetoid Gestures in a Deteriorating Parergasic—Schizophrenic (PCR 6min si). Demonstrates contrasting schizophrenic motility disorders.

A Parergasic Reaction (Schizophrenia) in a Person of Low Intelligence (PCR 16min sd). Shows stereotypic grimaces and speech vagueness, etc.; comparative study of motility disorders.

Catatonic Behavior in a Deteriorated Parergasic (Schizophrenic) Patient (PCR 8min si). Shows posture, hypertrophied neck muscles, and ritualistic and stereotypic methods of eating.

Symptoms in Schizophrenia (PCR 15min si). Reviews common symptoms of schizophrenia as they are exhibited by patients in the average mental hospital.

Experimentally Produced Neurotic Behavior in the Rat (PCR 23min si). Technique of producing experimental neuroticism in the rat is shown.

The Role of the Hypothalamus in Emotion and Experimental Neurosis (PCR)

Part 1—Conditioned Feeding Behavior in the Cat (17min si)

Part 2—The Production of Experimental Neuroses in Cats (17min si)

Part 3—The Role of the Hypothalamus in Conditioned Feeding Behavior (6min si)

Part 4—Direct Hypothalamic Conditioning (15min si)

CHAP. XII—APPRAISAL OF CONTROL: III. THE SERIES OF INADEQUATE SOLUTIONS FROM THE SOCIALLY ORIENTED TO THE PERSONALLY ELABORATED

Delusions and Hallucinations in a Senile Setting (PCR 8min sd). Shows patient demonstrating his imaginary power and what physical examination revealed.

Paranoid State and Deterioration Following Head Injury (PCR 14min sd). Tells story of mental-hospital patient, his rambling flow of talk that conveys disjointed, inconsistent, but dominant notions of persecution.

CHAP. XIII—PRECIPITATION AND PREDISPOSITION

Some Basic Differences in Newborn Infants during the Lying-in Period (NYU 23min si). Actual records of children from moment

of birth; shows importance of mother's emotional adjustment to child for total development.

Conflict Situations in Childhood (College Film Center 15min si). Experimental and clinical techniques of Kurt Lewin in study of behavior.

Not One Word (Harmon 15min si). Study of jealousy.

Balloons: Aggression and Destruction Games (NYU 20min sd). Demonstration of a projective technique for the study of aggression and destruction in young children.

Finger Painting (NYU 20min si C). Emphasizes the need for understanding the language of behavior of children.

Frustration Play Techniques (NYU 40min sd). Shows blocking games and frustration and hostility games; shows how children respond to intrusions, prohibitions, competitions, and frustration.

This Is Robert (NYU 80min sd). Traces the development of an aggressive, "difficult" child from two years to seven years; shows reasons for aggressiveness and corrective procedures.

CHAP. XIV—READJUSTMENT

Convulsive Shock Therapy in Affective Psychoses (PCR 15min si). Shows recent progress in use of convulsive therapy with affective psychotic states.

Institutional Training (Minn 15min si). Depicts activities of school and kindergarten at Faribault School for Feeble-minded.

Institutional Care of the Feeble-minded (Vineland 15min si). Modern institutional care of mental defectives is shown at Vineland Training School.

Handicapped Children and Clinical Types (College Film Center 14min si).

Narcosynthesis (PCR 20min si). Shows use of drugs as aid in psychotherapy.

Prefrontal Lobotomy in Treatment of Mental Disorders (PCR 21min si). Deals with treatment of functional psychoses.

Prefrontal Lobotomy in Chronic Schizophrenia (PCR 19min si). Illustrates the improvement that can be obtained in chronic schizophrenia by presenting four cases.

Psychiatry in Action (NYU 70min sd). Presents psychiatric techniques used in one of Britain's seven neurosis centers; portrays in detail many tests and different types of therapy.

Sources of Films Listed Above

College Film Center, 84 E. Randolph St., Chicago 1

Harmon Foundation, Division of Visual Experiments, 140 Nassau St., New York

Minn—University of Minnesota, Bureau of Visual Instruction, Minneapolis 14

Mitrano, A. J., 15 Glenbrook Ave., Park Hill, Yonkers, N. Y.

NJ—State of New Jersey, Department of Instruction and Agencies, Trenton, N. J.

NYU—New York University, Film Library, Washington Square, New York 3

PCR—Psychological Cinema Register, Pennsylvania State College, State College, Pa.

Rutgers Films, Rutgers University, Box 78, New Brunswick, N. J.

C. H. Stoelting Company, 424 N. Homan Ave., Chicago

Tufts College, Boston, Mass.

Vineland Training School, Vineland, N. J.

Warden and Gilbert, Psychological Laboratory, Columbia University, New York

Index

A

Ackerson, Luton, 59, 316
Acromegaly, 63
Adolescence, 228, 230
Aggression and passivity, 126–129
Aichorn, August, 309
Aiken, Conrad, 163, 309
Alcohol, 130–131, 245, 246
Allport, Gordon W., 86, 87, 89, 309
American Psychiatric Association, 14, 305–307, 309
American Psychological Association, 4
Amnesia, 156
Androgyny, 245–247
Anxiety, 19, 131–135, 151–155, 254
  appraisal of, 153
    Rorschach, 153
    Thematic Apperception Test, 153
  autonomic signs of, 131, 139
  reexperience of, in readjustment and therapy, 248–251
  solutions to, 134, 153–155, 160–162, 180–184
  state, 151–153
Aptitudes, special, 57
Arnott, P., 117, 312
Art in therapy, case report, 261–267
Arteriosclerosis, cerebral, 234–235, 238
Arthur, Grace, 54, 309
Asthma, 154, 155
Autobiography, patient's, 90–91

B

Babcock, H., 69, 309
Balken, Eva Ruth, 58, 144, 153, 157, 172–173, 195, 208, 214, 309, 313
Bartemeier, Leo H., 198, 244, 309
Bayley, Nancy, 46, 59, 309
Beach, Frank A., 183, 309
Beck, Samuel J., 145, 173, 174–179, 309
Bernreuter, R. G., 86, 87, 89, 143, 309
Billings, Edward G., 26, 27, 309
Binet, Alfred, 48, 52–53, 309
Birren, James E., 238, 310
Bleuler, E., 237
Bochner, Ruth, 157–160, 310
Bonafede, Vincent I., 239, 310
Bradley, Charles, 163, 310
Brenman, Margaret, 280, 310
Brown, Charles Brockden, vi
Bryan, Alice I., 44, 60, 311
Burlingame, C. C., 55–56, 69, 315

C

Cameron, Norman, 167, 170, 310
Cannon, W. B., 131, 310
Capacity, 17, 43–75
  appraisal of, 45–48, 53–54, 57–58
    case history, 45–46
    clinical observation, 46–47
    interview, 47–48
    Rorschach, 57–58
    Thematic Apperception Test, 57–58
    Wechsler-Bellevue, 53–54
  concepts of, 43–45
  limitation in development of, 62–67
  mechanism by which affected, 61–62
  reductions of, 67–75
Case reports, art sessions with child, 261–267
  brain tumor, 142
  depression, 214
  epileptic behavior, 197, 202–204
  head injury, 239–240
  hyperactivity in child, 219
  hypochondriasis, 186–188

Case reports, hysteria, 26, 158–160
illness, 232–233
longitudinal presentation of hysteria, 26
manic activity, 219, 219–224
moron, Binet test performance, 65–67
multiple sclerosis, 188–189
neurasthenia, 186–188
nondirective therapy, 280–301
obsessive-compulsive neurosis, 208
organic brain disease, 69–70, 70–71
paranoid schizophrenia, 71–73
play sessions with child, 258–261
psychasthenia, 208
psychopathic personality, 95–103
psychotic deterioration, 71–73
schizophrenia, 71–73, 142–143, 175–179
sexual deviation, 109–120
Catatonia, 164, 210
Cather, Willa, 163, 310
Cattell, Psyche, 46, 310
Caughey, J. L., Jr., 245–246, 310
Cerebrotonia, 241–243
Child, 93, 132, 136
clinical approach to, 31–32
frustrations of, 227–230
introversion and, 136–137, 162–163
mental development of, 59–62, 67
reduction of capacity in, 74–75
Rorschach of, 146–149
schizophrenia and, 163
sexual development of, 77–83
tests of capacity of, 52–54
Childhood, of hypomanic patient, 220
of psychopathic personality, 95
of schizophrenic patients, 238
of sexual deviate, 112–113, 119
sibling rivalry, 257–261
Clark, M. P., 44, 310
Cleckley, Hervey, 93–94, 102, 310
Clinical psychology, 6–10
relation of, to delinquency, 9–10
to educational and vocational guidance, 8–9
to medicine, 6–8
Clinical psychology, relation of, to personnel and industrial psychology, 9
Clinician, role of, 268–303
Cofer, C. M., 169, 312
Coghill, G. E., 75, 310
Compulsion, 190
Concept formation, 54–57
Concepts, abstract, 56
Concussion, 235–236
Conflicts, focal, 165–166
Congenital factors, 63
Conrad, H. S., 69, 312
Consciousness, loss of, 235–236
Constitution, 240–247
Continuum, hysteria-schizophrenia, anxiety and, 180–184
nature of conflicts and, 180–182
readjustment and, 251, 253, 273–277
recency of conflicts and, 180
sexual orientation and, 180–184, 244–247
symptomatology and, 180–184, 224–225
therapy and, 251, 253, 273–277
Control, 17, 19, 130–225
clinical methods in appraisal of, 137–140
Minnesota Multiphasic Personality Inventory, 143–144
observation, 138–140
Rorschach, 144–150
Wechsler-Bellevue, 141–142
Conversion, 154
Cornell, E. L., 54, 310
Coxe, W. W., 54, 310
Cretinism, 63

D

Darley, John G., 86, 310
Davidoff, Eugene, 239, 310
Deficit, psychological, 68
Delinquency, 9
Dementia praecox, 142, 163, 229 (*See also* Schizophrenia)
Denny-Brown, D., 239, 310

Depression, 209–215
case history, 210–211
methods of appraisal, 210–215
Minnesota Multiphasic Personality Inventory, 211–214
Rorschach, 215
Thematic Apperception Test, 214
Deterioration, 67–75
case reports, 71–72, 72–73
Deutsch, Helene, 124, 310
Development, 59–64, 227–230
and Rorschach, 146–149
Deviation, sexual, case report, 109–120
Diabetes, 154, 208, 283
Disease, 7, 23, 36–42
brain, 234–235
case reports of, 69–70, 70–71
hay fever, 155
heart, 155
mental, 7, 13, 14
primary concern of physician, 5, 36–42
sex incidence of, 245–247
skin, 183
Doolittle, George M., 239, 310
Draper, George, viii, 245–246, 310
Drawing of a man (Goodenough), 54
Due, Floyd, 90
Dunbar, Flanders, viii, 155, 208, 310
Dupertuis, C. W., 245–246, 310
Dysfunction, pituitary, 63
Dysmenorrhea, case report, 158–160
Dysrhythmia, cerebral, 196, 244
in epilepsy, 196

E

Ebert, E. H., 312
Ectomorphy, 242–243
Electrocardiogram, 38
Electroencephalogram, 38, 196, 203, 243–244
Encephalitis, 6, 234–235
and hyperactivity, 218–219
Endocrinology, 39–41, 106
Endomorphy, 242–243
Epilepsy, 196
Epilepsy, aura in, 196–197
grand mal, 196, 197
and heredity, 244
petit mal, 196, 197
Epileptic behavior, 195–204
appraisal of, 200–204
case history, 201–204
Rorschach, 200–204
case reports, 197, 202–204
Eppinger, Hans, 182, 183, 310
Erickson, Theodore C., 197, 314
Erikson, E. H., 90, 310
Examination, physical, in appraisal of neurasthenia, 184–185
general, 36–37
special, 37–42
endocrinological, 39–41
eyes and ears, 41
neurological, 38–39
pediatric, 41–42
Exhibitionism, 128
Expression, emotional, 255–303
Extroversion, 135

F

Factor analysis, 44
Fear, 132
Feeble-mindedness, 64–67
Fetal period, 227–228
Fetishism, 128
Films, 317–321
Freud, Sigmund, vii, 77, 89, 206, 237, 277–279, 310, 311
Frigidity, 123, 183
Frustration, 18, 137, 226–236, 240, 257
and anxiety, 133–135
and fantasy, 162–163
heterosexual, 122-126

G

Garrett, Henry, 44, 60, 311
Gay, James R., 73, 313
Geriatrics, 231
Gesell, Arnold, 46, 311
Gill, Merton M., 280, 310
Goldfarb, W., 311

Goldstein, Kurt, viii, 56, 167, 311
Goodenough, Florence, 54, 311
Gramlich, F. W., 117, 312
Gray, C. Truman, 57, 311
Greenwood, Edward D., 200, 313
Grinker, Roy R., 276, 279, 311
Growth, normal mental, 59–61
Guirdham, Arthur, 200, 311
Guttman, E., 261, 311

H

Halpern, Florence, 157–160, 310
Handicap, physical, 64
Hanfmann, Eugenia, 56, 167, 168, 311
Harrower-Erickson, M. R., 200, 312
Hathaway, Starke R., 87, 143, 186–189, 312, 314
Healy, William, 54, 312
Hebb, D. O., 74–75, 312
Hebephrenia, 164
Hemphill, R. E., 198, 312
Henry, George W., 109–120, 312
Heredity, 62–63, 243–244
Hertz, M. R., 145, 146, 312
Hertzman, Max, 312
Hess, Leo, 182, 183, 310
Heterosexual frustration, 122
Hildreth, Harold M., 142–143, 161, 312
Hill, Joel M., 142–143, 161, 312
History, case, 20–29
  in appraisal of, capacity, 45–46
    depression, 210–211
    epileptic behavior, 201–204
    homosexualtiy, 109–120
    hypochondriasis, 185
    hysteria, 201, 202
    manic activity, 219–224
    motivation, 83–85
    neurasthenia, 185
    paranoia, 206
    psychopathic personality, 95–97
    schizophrenia, 71–73, 142–143, 175
Homosexuality, 103–120
  appraisal of, case history, 109–120
    Terman-Miles, 117
  in paranoia, 206, 208
Hostility, in epileptic behavior, 199, 202
  in paranoia, 206
  in readjustment, 257
  release of, 257–270
Humm, D. G., 199, 312
Hunt, J. McV., 169, 312
Hunt, W. A., 165, 174, 313
Hyperactivity, in child, 219
Hypertension, 155
Hyperthyroidism, 245, 246
Hypnosis, 272, 280
  drug, 276
Hypochondriasis, 185–189
  case report, 186–188
  study of, case history, 185–189
    Minnesota Multiphasic Personality Inventory, 185–189
    physical examination, 184–185
    Rorschach, 189
    Thematic Apperception Test, 189
Hypomania, 215–225
  appraisal of, case history, 219–224
    Minnesota Multiphasic Personality Inventory, 216–218
    Rorschach, 222–223
    Thematic Apperception Test, 223
    Wechsler-Bellevue, 221–222
Hysteria, 19, 155–160
  appraisal of, case history, 201–202
    Minnesota Multiphasic Personality Inventory, 156–157
    Rorschach, 157–160
    Thematic Apperception Test, 157
  case reports, 26, 158–160
  differential diagnosis of, 201–202

I

Idiot, 65
Illness, 23, 28, 141, 184–185, 231–234
Imbecile, 65
Immaturity, mental, 67
Impotence, 123, 183, 230
Infantilism, 93
Inheritance of psychopathology, 243–244
Injury, 55, 239–240

Injury, brain, 55
head, 239–240
Insight, 251–256
Intelligence, general, 43–45
Interview, clinical, in study of capacity, 47–48
of motivation, 83–85
Introversion, 135–137
in Rorschach, 149
Inventory, Bernreuter Personality, 85, 86, 89, 143, 309
Minnesota Multiphasic Personality (*See* Minnesota Multiphasic Personality Inventory)
Involution, 123
melancholia, 210, 230–231
(*See also* Depression)
Irwin, Orvis, C., viii, 75, 312

J

Jackson, Charles, 108, 312
Jones, H. E., 69, 312
Jung, C. G., vii, 237, 312

K

Kardiner, Abram, viii, 235–236, 312
Karwoski, T. F., 117, 312
Kasanin, Jacob, 56, 167, 237, 311, 313
Kay, L. W., 146, 313
Kendig, Isabelle, 313
Kelley, Douglas McGlashan, 91, 145, 153, 173, 174, 189, 200, 313
Klopfer, Bruno, vii, 91, 145, 146, 153, 173, 174, 189, 200, 313
Kohs, S. C., 54, 313
Kraepelin, E., 218, 313
Kretschmer, E., 241
Kuhlen, R. G., 102
Kupper, Herbert J., 202–204, 315
Kutash, Samuel B., 97, 313

L

Landis, C., 165, 174, 313
Lashley, K. S., 75, 313
Lemere, Frederick, 200, 313
Lennox, William G., 200, 313
Levy, David M., 90, 258–261, 268, 269, 278, 313
Lidz, Theodore, 73, 313
Lindner, Robert M., 100, 280, 313
Lodge, G. T., viii, 27
Louttit, C. M., 65–67, 313

M

McGaughey, W. M., 197
McKinley, J. Charnley, 87, 143, 186–189, 312, 314
Maclay, W. S., 261, 311
Madigan, Virginia W., 280–301, 313
Manic activity, 215–225
appraisal of, case history, 219–224
Minnesota Multiphasic Personality Inventory, 216–218, 224
Rorschach, 222–223
Wechsler-Bellevue, 221–222
case report, 219–224
Margulies, Helen, 146, 312, 313
Masochism, 127
Masserman, Jules H., 144, 153, 157, 172, 195, 208, 214, 313
Masturbation, 80–81, 125, 181, 183, 229, 247
and personal elaboration, 165
Menopause, 123, 210, 230–231
Mental deficiency, 64–67
Merrill, Maud A., 52, 53, 316
Mesomorphy, 242–243, 245
Metabolism, basal metabolic rate, 40
and sex, 245
Meyer, Adolph, 27
Migraine, and epileptic behavior, 197
Miles, Catherine Cox, 86, 87, 89, 109, 117, 316
Minnesota Multiphasic Personality Inventory, in study of, control, 143–144
depression, 211–214
hypochondriasis, 185–189
hysteria, 156–157
manic activity, 216–218, 224
motivation, 87–89
multiple sclerosis, 188–189

Minnesota Multiphasic Personality Inventory, in study of, neurasthenia, 185–188
obsessive-compulsive neurosis, 193–195
paranoia, 206–208
psychasthenia, 193–195
psychopathic personality, 94–95, 101–102
schizophrenia, 170–172
Mongolism, 63
Morgan, Christiana, 90, 314
Moriarty, John D., 198, 314
Moron, case report, 65–67
Moros, Nathan, 239, 314
Motion pictures, 317–321
Motivation, 15–17
appraisal of, case history, 83–85
clinical observation, 83–85
interview, 83–85
Minnesota Multiphasic Personality Inventory, 87–89
Rorschach, 91–92
Thematic Apperception Test, 90
methods of study, 76–92
Multiple sclerosis, case report, 188–189
Murray, Henry A., vii, 90, 314

N

Narcoanalysis, 279
Narcosynthesis, 279
Naumburg, Margaret, 261–267, 314
Nelson, Virginia L., 44, 60, 314
Neurasthenia, 19, 184–190
appraisal of, case history, 185–189
Minnesota Multiphasic Personality Inventory, 185–189
physical examination, 184–185
Rorschach, 189
Thematic Apperception Test, 189
case report, 186–188
Neurosis, obsessive-compulsive, 190–195
appraisal of, 190–195
clinical observation, 192–193
Minnesota Multiphasic Personality Inventory, 193–195
Neurosis, obsessive-compulsive. Rorschach, 195
Thematic Apperception Test, 195, 208
case report, 208
traumatic, 235–236
Nomenclature, of American Psychiatric Association, 14, 226, 305–307
Noyes, Arthur P., viii, 166, 199, 314

O

Observation, clinical, in appraisal of, capacity, 46–47
control, 138–140
motivation, 83–85
obsessive-compulsive neuroses, 192–193
psychasthenia, 192–193
schizophrenia, 161–162
Obsession, 191
Oedipus complex, 83

P

Page, J. D., 165, 174, 313
Paper-and-pencil tests, 52, 143
Paralysis, general, 234–235
Paranoia, 205–208
appraisal of, Minnesota Multiphasic Personality Inventory, 206–208
Thematic Apperception Test, 208
case history, 71–72, 206
Paranoid schizophrenia, 165
Paresis, 234–235
Pattern, test, 71
Patterns of behavior, emergence of, 44
Penfield, Wilder, 197–314
Pennington, L. A., 102
Perl, Ruth E., 44, 60, 311
Personality, epileptic, 199–200
Phobia, 190
Physical examination, importance of, 36
Physique and personality, 241–243
Pictorial completion, Healy, 54, 168
Piotrowski, Zygmunt A., viii, 73, 74, 145, 215, 314

Pituitary dysfunction, 63
Play, case report, 258–261
  as therapy, 257–261
Pneumoencephalogram, 38
Precipitation, 226–236
Predisposition, 236–247
Prematurity, 112, 228
Projection, 85
Psychasthenia, 190–195
  appraisal of, clinical observation, 192–193
    Minnesota Multiphasic Personality Inventory, 193–195
    Rorschach, 195
    Thematic Apperception Test, 195, 208
  case report, 208
Psychiatry, 7
Psychoanalysis, 7, 250, 278–280
Psychoanalyst, 82–83
Psychogalvanometer, 39
Psychometrics, 5
Psychopathic personality, 89, 93–103
  appraisal of, case history, 95–97
    Minnesota Multiphasic Personality Inventory, 94–95, 101–102
    Rorschach, 100–101
    Thematic Apperception Test, 97–100
    Wechsler-Bellevue scale, 97
Psychopathology, masculine *vs.* feminine, 180–184
Psychosexual development, 24–25, 77–81, 82–83, 124
Psychosis, 160–162
  epileptic, 239
  Karsakoff's, 246
  puerperal, 230
  schizo-affective, 218
  traumatic, 235–236, 239
Psychosomatics, 19, 135, 154–155
  in epilepsy, 200, 202–204
  features of, in psychasthenia, 190, 191–197
Psychosurgery, 272, 274
Psychotherapy, 272–303
  nondirective, 280–301
Pyromaniac, 128

R

Rapaport, David, 56, 314
Rapport, 30
Rationalization, 84–85
Readjustment, 248–303
Reduction of capacity, 67–75
  appraisal of, Rorschach, 73–74
    Wechsler-Bellevue, 69–71, 73
  concept formation tests, 56–57
Reexperience of anxiety, 248–251, 254
Reichard, Suzanne, 56, 314
Release, emotional, 255–303
Reliability, test, 49, 52
Repression, 18
Richards, T. W., 44, 59, 60, 132, 314, 315
Richardson, Henry Handel, 234, 314
Richmond, W. V., 313
Rickers-Ovsiankina, M., 173, 314
Roe, A., 315
Rogers, Carl R., viii, 277, 280, 315
Rogers, H. W., viii
Rorschach, H., vii, 144, 145, 200, 315
Rorschach (test), and development, 146–149
  in study of, anxiety, 153
    capacity, 57–58
    control, 144–150
    depression, 215
    epileptic behavior, 200–204
    hypochondriasis, 189
    hysteria, 157–160
    manic activity, 222–223
    motivation, 91–92
    neurasthenia, 189
    obsessive-compulsive neuroses, 195
    psychasthenia, 195
    psychopathic personality, 100–101
    reduction of capacity, 73–74
    schizophrenia, 173–179
Rosanoff, Aaron J., 182, 315
Rothschild, David, 238, 315
Ruesch, Jurgen, 56, 316
Russell, John A., 218–219, 315

S

Sadism, 127
Sanford, R. Nevitt, viii, 90, 315
Scale, Binet, 52–53
  example of performance, 65–67
  Shipley-Hartford Retreat, 55–69
  Wechsler-Bellevue (*see* Wechsler-Bellevue)
"Scatter," 71
  in schizophrenia, 71–73, 168–169
Schachtel, A. H., 315
Scheerer, Martin, 56, 311
Scheinfeld, Amram, 247, 315
Schilder, Paul, 198, 315
Schizophrenia, 19, 162–179, 229
  beginnings of, 237
  in childhood, 163
  language in, 170
  literary production of, 166
  sex incidence of, 247
  study of, case history, 71–73, 142–143, 175
    clinical observation, 162–163
    Healy Pictorial Completion Test, 167–168
    Minnesota Multiphasic Personality Inventory, 170–172
    Rorschach, 173–179
    Thematic Apperception Test, 172–173
    Wechsler-Bellevue, 71–73, 168–169
Senescence, 231
Sexual adjustment, 121
Sexual orientation in psychopathology, 180–184, 224–225, 245–246
Sexuality, 77–83
Shakow, I., 315
Sheldon, W. H., 241–243, 245, 315
Shipley, Walter C., 55–56, 69, 315
Shirley, Mary Margaret, 46, 315
Shock, 197
  electric, 197
  insulin, 274–275
  metrozol, 197
  therapy, 198, 272, 273
Simon, Th., 309
Skills, special, 57
Skin resistance, 39
Solution to anxiety, 134, 153–155, 160–162, 180–184
Somatotonia, 241–243, 245
Somatotype, 241–243
Sontag, Lester W., viii, 132, 315
Spiegel, John P., 276, 280, 311
Stoddard, George D., 59, 315
Strong, E. K., Jr., 86, 310, 315
Sublimation, 108
Suicide, 209, 214
Sympathicotonia, 182, 183
Syndromes, 13
Syphilis, 6, 227, 234–235

T

Terman, Lewis, M., 52, 53, 86, 87, 89, 109, 117, 315, 316
Tests, administration, general procedure, 49–50
  of capacity, in common use, 52
  concept formation, 54–57
  Healy Pictorial Completion, II, 54
  in schizophrenia, 167–168
  reading, 57
  Rorschach (*see* Rorschach)
  selection of, 50–52
  sorting, 56
  Terman-Miles, 86–87
    in case study, 117
  Thematic Apperception (*see* Thematic Apperception Test)
  Vigotsky, 56
Thematic Apperception Test, anxiety, 153
  capacity, 57–58
  depression, 214
  hysteria, 157
  manic activity, 223
  motivation, 90
  obsessive-compulsive neuroses, 195, 208
  paranoia, 208
  psychasthenia, 195, 208
  psychopathic personality, 97–100
  schizophrenia, 172–173
Therapy, 271–303

Therapy, drug, 272
nondirective, 280–301
case report, 280–301
shock, 198, 272, 273
Thickstun, James T., viii
Thurstone, L. L., 59, 316
Tietze, Christopher, 73, 313
Titley, W. B., 210 211, 238, 316
Transference, 269–271, 278–280
Trauma, birth, 228
head, 235 236
and psychosexual development, 81
and psychosis, 239
Tumor, brain, case report, 142

U

Ulcer, 135, 154, 182–183, 192, 245–246

V

Vagotonia, 182, 183
Validity, test, 51
Vander Veer, Adrian H., 144, 309
Veo, Louise, 237, 313
Verbalization, in therapy, 267–268
Vigotsky, L. S., 56, 73, 167, 316
Viscerotonia, 241- 243, 245
Vorhaus, P. G., 146, 313, 316
Voyeurism, 128

W

Wadsworth, G. W., 199, 312
Wallace, Robert F., 132, 315
Wechsler, David, 53, 69, 70–74, 97, 141–142, 222, 316
Wechsler-Bellevue Scale, 53 -54
in study of, capacity, 53–54
control, 141–142
manic activity, 221 222
psychopathic personality, 97
reduction of capacity, 69–71, 73
schizophrenia, 71–73, 168–169
Weil, André A., 198, 314
Wells, F. L , viii, 56, 316
Wenger, M. A., 182, 316
Wolff, Harold G., 135, 316
Wright, Erik, 90
Wylie, Philip, 232–233, 316

Z

Zones, erogenous, 79